Hamelin, Valerie

From: Mundie, Robert
Sent: November 3, 2017 03:58 PM
To: Alimohamed, Natasha
Subject: FW: Death in Custody protocol
Attachments: 2016-04-21 EC 03e Operations Branch Guidelines for Serious Incident E.pdf; 2016-04-21 EC 03e Operations Branch Guidelines for Serious Incident F.pdf; 2016-04-21 EC 03f ToR DG After Incident Review Working Group E.pdf; 2016-04-21 EC 03f ToR DG After Incident Review Working Group F.pdf; 2016-06-29 EC Ad hoc 0 RoD Approved E.pdf; 2016-06-29 EC Ad hoc 0 RoD Approved F.pdf; 2016-04-21 EC 03c Protocol for Responding to Death or Serious Injury in Custody E.pdf; 2016-04-21 EC 03c Protocol for Responding to Death or Serious Injury in Custody F.pdf; 2016-04-21 EC 03d Overarching Guidelines for Serious Incident E.pdf; Death In Custody--Comms Guidelines_FINAL_ENG.docx; Public Communications Protocol Death In Custody 201610 FINAL.DOCX; Public Communications Protocol Death In Custody 201610 FINAL.DOCX; Public Communications Protocol Death In Custody 201610 FINAL_FR.DOCX

Resending.

From: Mundie, Robert
Sent: October 31, 2017 12:08 PM
To: Ossowski, John <John.Ossowski@cbsa-asfc.gc.ca>; Namiesniowski, Tina <Tina.Namiesniowski@cbsa-asfc.gc.ca>; Saunders, Tom <Tom.Saunders@cbsa-asfc.gc.ca>; Watkinson, Julie <Julie.Watkinson@cbsa-asfc.gc.ca>; Cloutier, Jacques <Jacques.Cloutier@cbsa-asfc.gc.ca>; Vinette, Denis R. <Denis.Vinette@cbsa-asfc.gc.ca>; Vragovic, Goran <Goran.Vragovic@cbsa-asfc.gc.ca>; Bolduc, Martin <Martin.Bolduc@cbsa-asfc.gc.ca>; Hill, PeterD(CBSA) <Peter.Hill@cbsa-asfc.gc.ca>; Easton, Erika-Kirsten <Erika-Kirsten.Easton@cbsa-asfc.gc.ca>; Proulx, Dan <Dan.Proulx@cbsa-asfc.gc.ca>; O'Connor, Stephen <Stephen.O'Connor@cbsa-asfc.gc.ca>; O'Donoughue, Jen <Jen.O'Donoughue@cbsa-asfc.gc.ca>; Dunne, Brendan <Brendan.Dunne@cbsa-asfc.gc.ca>; Rigg, Jacqueline <Jacqueline.Rigg@cbsa-asfc.gc.ca>; Blair, Claudette <Claudette.Blair@cbsa-asfc.gc.ca>; Chénier, Maurice <Maurice.Chenier@cbsa-asfc.gc.ca>
Cc: Garbers, Raquel <Raquel.Garbers@cbsa-asfc.gc.ca>; Mackenzie, Joey <Joey.Mackenzie@cbsa-asfc.gc.ca>; Brunatti, Andrew <Andrew.Brunatti@cbsa-asfc.gc.ca>; Melchers, Charles <Charles.Melchers@cbsa-asfc.gc.ca>; Keeler, Carolyn <Carolyn.Keeler@cbsa-asfc.gc.ca>; Giolti, Patrizia <Patrizia.Giolti@cbsa-asfc.gc.ca>; Raider, Marc <Marc.Raider@cbsa-asfc.gc.ca>; Comeau, Jean-Marc <Jean-Marc.Comeau@cbsa-asfc.gc.ca>; Quinn, Robyn <Robyn.Quinn@cbsa-asfc.gc.ca>; Bindner, Melissa <Melissa.Bindner@cbsa-asfc.gc.ca>; Blanchard, NathalieX <NathalieX.Blanchard@cbsa-asfc.gc.ca>; Cyr-Carriere, Alexandra <Alexandra.Cyr-Carriere@cbsa-asfc.gc.ca>; Emmanuel, Marjorie <Marjorie.Emmanuel@cbsa-asfc.gc.ca>; Braham, Stephen <Stephen.Braham@cbsa-asfc.gc.ca>; Shivji-Prasad, Shahina <Shahina.Shivji-Prasad@cbsa-asfc.gc.ca>; Legault, Anne <Anne.Legault@cbsa-asfc.gc.ca>; Racicot, Kristine <Kristine.Racicot@cbsa-asfc.gc.ca>; Gorley, Anik <Anik.Gorley@cbsa-asfc.gc.ca>; Thibodeau, MarcR (HRB-HQ) <Marc.Thibodeau2@cbsa-asfc.gc.ca>; Desmarais, Carl <Carl.Desmarais@cbsa-asfc.gc.ca>; Lutfallah, Jennifer <Jennifer.Lutfallah@cbsa-asfc.gc.ca>; Janes, Lisa CBSA-ASFC <Lisa.Janes@cbsa-asfc.gc.ca>
Subject: Death in Custody protocol

As per the EC-approved protocol (effective April 21, 2016), please find the relevant documents (in pdf format) which relate to the incident and investigation process, as well as the communications protocol, effective October 26, 2016 (Word docs).

Slide 7 of the pdf document "2016-04-21 EC 03c" outlines in a nutshell the various responsibilities on Day 1, Day 1 to 15, and ongoing (see slide below).

Given that a death in custody occurred on October 30, 2017, please note the roles of lead RDG, VP Ops, VP CAB and DG Comms. My role is to ensure that this protocol is followed and to advise Senior General Counsel. Communications directorate and the GTA region made a public announcement via various media formats yesterday. Internally, I am expecting that GTAR and Ops have internally communicated this message.

The EC decision regarding deaths in custody is to manage each case centrally from headquarters and that this process be formalized as part of the National Detention Strategy. Over the coming two weeks the fact finding review conducted within Ops and the region will lead to a recommendation to the President as to whether an Incident Management Working Group (IMWG) be convened. Coordination will continue to be through the Corporate Affairs Branch, and I will designate a lead should we move towards an IMWG.

Merci pour votre collaboration.

Robert J. Mundie

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Canada Border Services Agency / Government of Canada
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Vice-président par intérim, Direction générale des services intégrés
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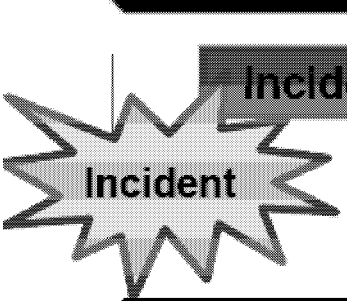
Government of Canada / Gouvernement du Canada

Canada

Incident and Investig



Incident Management Phase

Incident Investigati

Day 1

Lead RDG
- Activate Local CIMP and BCP if required
- Activate ICS model and Regional Ops Ctr
- Ensure continued SEN reporting
- Engage Regional Comms (with support from NHQ Comms)
- Support on scene 3rd party investigations
- Return to normal ops as soon as practicable

VP Ops
- Direct operational response and national reporting (Sitreps, Issue Fact sheets, etc.)
- Direct Ops Branch engagement, support to region
- Issue Border Alert if POE closed
- Inform Departmental Security Officer (DSO)

VP CAB and DG Comms
- Ensure protocol is followed and message is posted.
- Advise CBSA's Senior General Counsel

Other VPs
- Be prepared for requests for support

Day 1 – Day 1

Lead RDG
- Conduct Fact Finding Re
  regional resources (if no
  investigations will take pl
- Produce Due Diligence F
- Support local workforce
- Support ongoing 3rd part
  investigations(Police, Co
- Address any issues relati
  officer/client safety

VP Ops
- Direct Fact Finding Revie
- Seek engagement of DG
  other DGs to conduct or
  Finding Review
- Make recommendation t
  convene the Incident Ma
  Working Group(IMWG)

VP Comptrollership
- Provide DG SPSD and o
  appropriate to support V
  Finding Review.

Other VPs
- Support as required

DOCUMENT 2

OPERATIONS BRANCH GUIDELINES FOR REPORTING AND INVESTIGATING A SERIOUS INCIDENT IN CBSA CUSTODY OR CONTROL

DRAFT – April 18, 2016

Table of Contents

Preamble

As employees of the Canada Border Services Agency (CBSA), we all play an important role in enabling the Agency to fulfill its mandate of supporting national security and public safety priorities. This document provides guidance to CBSA Operations Branch Management when responding to and reporting on a serious injury or death in CBSA custody, in a manner consistent with the mandate of CBSA, and our objectives to demonstrate responsibility, accountability, and transparency of CBSA's activities.

Rapid and consistent responses to serious injury or death in CBSA custody are required to achieve our objectives, and to assure the public that the safety of the public, detainees, and staff is CBSA's top priority. We can do this by:

- initiating an investigation when any serious injury or death occurs in CBSA custody as soon as all immediate facility or life safety issues have been addressed;
- reviewing and analyzing report recommendations and rapidly taking appropriate action following an incident;
- sharing any findings that could reduce the likelihood or impact of a similar incident occurring in the future;
- working with Legal Services and HQ, cooperating with the Police, Coroner or other investigative Agency in their investigation of the incident, while ensuring that the CBSA does not and is not seen to attorn to the jurisdiction of the Coroner.

Introduction

These guidelines are intended to be activated once all immediate responses to the incident have been initiated and the Incident Command System has been implemented. Immediate responses will include emergency scene management, medical emergencies, protection of critical infrastructure and activation of business continuity plans as necessary. Once all emergency management responses have been concluded, law enforcement partners have completed their preliminary on scene investigation, and the situation is appropriately contained, an investigation of the incident becomes a priority. This document provides guidance on the fact-finding investigation, documentation and reporting of the incident.

The guideline is divided into three separate but connected responses to a serious incident:

1. Initial reporting and the transition to ongoing situational reporting (Incident Management Phase)

2. The fact-finding investigation into the circumstances of the incident (Incident Investigation Phase)
3. The Management Response and Action Plans that flow from the investigation (Incident Follow-up Phase)

Definitions

After Incident Report – Produced by the Director Generals' After Incident Review Working Group, this report is a compiled analysis of the Due Diligence Report, the Regional Management Response and Action Plan, current policies, security requirements, ongoing risks to detainees and Agency operations, and previous Coroner's recommendations for such incidents, in order to determine whether recommendations should be made and actions taken at the National level.

CIMP – A critical incident is defined as a natural or man-made traumatic event outside of the range of normal experience that may occur suddenly and unexpectedly causing emotional or physiological trauma. It may be an emergency or a disaster, with effects on staff, facilities and operations. It has the potential to significantly and adversely impact the overall functions of the Canada Border Services Agency (CBSA) by causing serious injury or loss of life, significant property damage, threat to services and/or any disruption of border operations. A critical incident management plan (CIMP) is a formal plan to describe how an organization will respond to a critical incident. CIMPs are normally approved at the Regional Director General level. A detailed explanation of a CIMP is provided at:

Due Diligence Report – Produced by the Region, the purpose of the Due Diligence Report is to document the results of the fact-finding investigation, to review the circumstances surrounding the incident, to identify any areas requiring more in depth subsequent investigation, and to rapidly identify and rectify any immediate breaches of existing standards, policies or protocols or any other factors that may need to be modified. Through the Fact Finding review and the production of a Due Diligence Report, and the Management Response and Action Plan, the Agency may ensure that any immediate and necessary corrective action has been taken at the facility or in the Region in relation to the incident.

Fact Finding Review - A fact-finding investigation into an incident that is carried out on site by qualified representatives from within the Region. The fact finding review will examine the circumstances of the incident by: interviewing CBSA employees, Contractors and non-CBSA employees; reviewing all relevant documents including CCTV footage, and by exploring any other relevant avenues of investigation. Once the regional fact-finding investigation is complete, HQ Professional Standards Investigations may choose to investigate further.

The Regional Fact Finding Investigation does not supersede or replace any police, coroner or other external investigation that may be taking place concurrently with the CBSA investigation.

ICS – The Incident Command System (ICS) provides a management system which organizes the functions, tasks and staff within the overall emergency response. It transforms the confusion of an emergency into a well-managed response by recognizing "people" as the primary assets and providing them the critical answers to "Who's in Charge?" and "What's my Job?". (1) A detailed description of the ICS components, roles and responsibilities and actions is located at:

Management Response and Action Plan – Developed by a committee chaired by the relevant Regional Director in response to the recommendations of the Due Diligence Report, and to be delivered to the Headquarters Incident Management Working Group, for review by the Director Generals' After Incident Review Working Group.

National Management Action Plan – Developed by the Director Generals' After Incident Review Working Group to address issues identified by the Due Diligence Report which are national in scope.

NBOC – The National Border Operations Centre (NBOC) is responsible for ensuring national security through situational awareness, targeting and intelligence, and a coordinated tactical response to emergencies, threats, and issues management. The NBOC is responsible for monitoring the current state of operations, maintaining and enhancing the flow of information between regional enforcement partners and our operations, responding to and managing unforeseen events, and reviewing and sharing intelligence and enforcement information concerning illegal border activities, contraband, illegal migration, national security and terrorism risks.

Serious Incident – Any incident that involves the death or serious bodily injury of a person in CBSA custody, whether such injury or death results from natural causes, self-infliction, accident or the actions of a third party. Serious bodily injury is defined as a medical condition that is life threatening.

SEN – A Significant Event Notification (SEN) is an information reporting mechanism used within the CBSA. When an incident or event meets the threshold identified in the CBSA's Incident Reporting Criteria (IRC), details on the encounter are reported to the Border Operations Centre (BOC) through a SEN. Depending on the nature of the event, the Border Operations Centre (BOC) will disseminate the information further through a subsequent BOC SEN to an approved distribution list.

Pertinent Legislative Authorities:

Privacy Act

Immigration and Refugee Protection Act

Criminal Code of Canada

Customs Act

Roles and Responsibilities:

A. Initial Response and Reporting (Incident Management Phase)

Upon becoming aware of a serious incident, **District/Divisional Operational management** will:

1) Follow existing significant event Incident Reporting Criteria protocols and report details of the incident to the BOC via a Significant Event Notification (SEN).
2) Provide updates regarding the serious incident as they become available via reporting through the Regional Operations Centre (ROC, if activated) or through the standard SEN update process.
3) Involve local Employee Assistance Program (EAP) representatives and Critical Incident Stress Management (CISM) Coaches as needed.
4) Consider arranging Union/Management meeting; especially in the case of potential or actual work refusals.
5) Provide a briefing to staff; consider the synchronization of information with stakeholders and facility partners.

Upon receipt of the initial SEN, the **BOC** will:

1) Distribute the information in accordance with the Event Management Process
2) Advise the Operations Branch Duty Executive (ODE), who may already have been notified by the SEN issued from the field.
3) Disseminate a limited distribution SEN to senior executives and affected internal stakeholders regarding details of the incident.
4) Update the SEN as new information is received from the region.
5) As directed by the VP Operations, complete tempo reporting or Situational Reports at pre-defined intervals.
6) Conclude reporting once the serious incident is deemed complete and no further information is expected or required.

The BOC Issues Management Secretariat monitors the internal and external communication, media, social media and other relevant information sources to enhance situational awareness, and coordinates tasking and dissemination of Issues Facts Sheets, Case Chronologies and other supporting documents.

Upon notification by the BOC of a serious incident, the **Vice-President of Operations** will:

1) Direct the mechanism and frequency for reporting related to the incident. This will usually consist of establishing a single point of contact from within the Region for reporting purposes. The single point of contact may be the Regional Operations Centre or the District or Division office where the incident occurred/is occurring. The regular reporting mechanism is the Significant Event Notification Process, but in the event the incident is of longer duration, the VPO may direct the Region to produce a more detailed report. (Determination to be made with respect to whether a SEN, Issue Fact Sheet or Daily Situation Report is the best vehicle for such updates.)
2) Direct Operations Branch engagement and support to the region.
3) Issue Border Alert if a Port of Entry (POE) is closed.
4) Inform the Director General (DG) of Security and Professional Standards Directorate (SPSD) of the incident.

Upon notification, the **Vice-Presidents of other branches** will:

1) Be prepared to respond to requests for support.
2) Vice-President, Corporate Affairs will advise CBSA's Senior General Counsel of the serious incident and request legal support.
3) Vice-President, Corporate Affairs will seek support from Vice-President Comptrollership and Vice-President, Programs to ensure that the DG After-Incident Review Working Group begins preparation of the After Incident Report and the ensuing National Management Action Plan.

Upon notification of a serious incident, the relevant **Regional Director General** reporting to the Vice-President of Operations will:

1) Direct the activation of the local CIMP and BCP if required.
2) Direct the area involved to establish an ICS command structure with identified on scene Incident Commander and Executive lead. (Incident Commander and Executive lead are preferably not the same person but can be for a short duration)
3) Identify a single point of contact from within the Region for reporting purposes. The single point of contact may be the Regional Operations Centre (ROC) or the District or Division office where the incident occurred/is occurring. The regular reporting mechanism is the Significant

Event Notification Process, but in the event the incident is of longer duration, the Region may be required to produce a more detailed report.

4) Following direction from the VP of Operations, create a reporting mechanism and framework to report out to Senior Management and the BOC (i.e. ensuring continued SEN reporting). This will be a single point of contact that reports out from either the Regional Operations Centre or the District or Division office where the incident occurred. The Detailed Situation Report will be used to report out details as directed by the RDG. The Report can be used as a situation update product around the time of incident and/or during subsequent events such as public inquiries, inquests or hearings. (See Annex 1 - Detailed Situation Report template.)
5) Ensure full cooperation with the appropriate law enforcement organization assigned to investigate the incident and establish one CBSA representative to be the ongoing point of contact.
6) Direct the engagement of Regional Communications if this has not already occurred.

Upon being notified of a death in custody, the **Assistant Director of Regional Communications** shall:

1) At the direction of the Regional Director General, implement the *Public Communications Protocol — In-Custody Death*. This includes working with HQ to provide information about and liaison with communications activities of partners and stakeholder, draft communications products as required, and secure direction and approvals.

B. Incident Investigation (Incident Investigation Phase)

Following emergency response and preliminary investigation at the scene by local law enforcement and within 7 days of the incident:

The **Vice-President of Operations** will:

1) Determine whether other Regions, Directorates or Branches need to be engaged. (i.e. International Region)
2) In conjunction with the Regional Director General, the VP of Operations will request that a Fact Finding Review be conducted. The personnel tasked with conducting the Fact Finding Review will produce a Due Diligence Report within 60 days of the incident occurrence to document the facts, to identify whether there are areas requiring more in-depth investigation, and to quickly identify any immediate breaches or gaps in existing standards, policies, protocols or infrastructure at the facility or in the region. Because this is a regional report only, the findings, recommendations, and actions cannot extend beyond the area of responsibility of the RDG. (See Annex 2 - *Due Diligence Report* template)

The relevant **Regional Director General** reporting to the Vice-President of Operations will:

1) Direct the Operation involved to take immediate action on any urgent infrastructure, policy, or procedural risks that have been identified.
2) Begin organizing and preparing materials for any investigation, inquest, or court proceeding; support any ongoing, third party investigations (Police, Coroner etc.)
3) Work with Regional and HQ Communications to respond to media enquiries, consistent with all relevant communication policies and protocols, including: the Government of Canada Communication Policy, and the CBSA *Public Communications Protocol — In-Custody Death*
4) Support the local workforce and assign people in the appropriate District/Division to manage the work, including:
    a. Reporting incident to the respective embassy or consulate where applicable and provide a point of contact to manage ongoing communication.
    b. Reporting to NGOs in accordance with established agreements or MOUs (i.e. Canadian Red Cross Society).
    c. Establish appropriate contacts or working groups with stakeholders such as provincial Corrections in order to seek advice on corrective action and to coordinate operational and media relations responses.
    d. Begin organizing and preparing materials for any investigation, inquest, or court proceeding.
    e. Engage the CBSA Legal Services Unit for advice on any information disclosures to be made to local police authorities, investigating coroner's services, embassies or consulates or other parties.

The **Vice-Presidents of other branches** will:

1) Support as required.

The **President** will:

1) Assign the VP of Corporate Affairs to convene the HQ Incident Management Working Group (IMWG).

C. Management Response and Action Plan (Incident Follow-up Phase)

Upon completion of the draft Due Diligence report:

The relevant **Regional Director General** will:

1) Form a Regional review committee to review findings and recommendations from the Due Diligence Report and approve the final report within 60 days of the incident.
2) Prepare and take action on a Regional Management Response and Action Plan in response to any items identified in the Due Diligence Report within 75 days of the incident. (See Annex 3 – *Management Response and Action Plan* template).
3) Submit the finalised Due Diligence Report and draft Regional Management Response and Action Plan to the HQ Incident Management Working Group.

Upon receiving the final Due Diligence Report and Regional Management Response and Action Plan from the relevant RDG:

The **Vice-President, Corporate Affairs** will have ensured that CBSA's Legal Services Unit was made aware of the incident as soon as possible, and will convene a temporary incident management working group within 60 days of the incident to:

- Review the Due Diligence Report and the After Incident Report.
- Review on a regular basis the progress on the Management Response and Action Plan and the National Management Action Plan.
- Coordinate and manage internal decision-making.
- Manage the preparation of briefing notes for the Minister and the President, to provide updates on the work of the Agency.
- With the advice of Legal Services, manage the review and preparation of materials for any inquest, including consideration of the lawful release of personal information for the purpose of contacting family and witnesses and other releases that might be in the public interest.
- Manage the review and preparation of communications products, including consideration of the lawful release of personal information when the public interest outweighs the potential privacy impact.
- Ensure that management of the work remains a priority for all involved at headquarters.

Refer to the Terms of Reference for the HQ Incident Management Working Group ("Document 4" in this series), and associated templates.

The **Vice President of Operations** will:

1) Oversee the Due Diligence Report, recommendations and Management Action Plan through to completion.
2) Participate in the HQ IMWG to provide ongoing direction and support.

3) During an inquest or public investigation, ensure that Regional Operations are prepared and supported, and that daily or twice daily reporting occurs through the use of the Inquest or Public Inquiry Situation Reporting Template (see Annex 4).

The **Vice-Presidents of HRB and CB, and other branches if required,** will:

1) Participate in or provide representatives for the IMWG.
2) Provide ongoing direction and support.
3) Bring closure to regional and national level matters.

Annex 1
Detailed Situation Reporting Template

BOC sample template:

Draft Situation Report
Month XX, XXXX; HH:MM ET

TABLE OF CONTENTS | TABLE DES MATIÈRES

Note : Sections and content of this template to be modified according to the type of event/incident being reported

Back/Retour

BACKGROUND

Back/Retour

CBSA Operations

Details impact to CBSA operations, observations from field/region, etc.
This section is the primary location for updates, as SitReps continue.

Back/Retour

Communications

May include media summary, inquiries (actual or anticipated), social media, additional communications activities, etc.

Back/Retour

Next 24 hours

To include next steps by Region, BOC

To include date and time of next SitRep publication

Back/Retour

THIS INFORMATION IS CLASSIFIED PROTECTED A. IF YOU HAVE ANY QUESTIONS OR FOLLOW UP REQUESTS FOR DETAILED INFORMATION, PLEASE CONTACT THE BORDER OPERATIONS CENTRE AT 613-960-6001.

CES RENSEIGNEMENTS SONT CLASSIFIÉS PROTÉGÉ A. SI VOUS AVEZ DES QUESTIONS OU DÉSIREZ FAIRE UN SUIVI DE DEMANDES DE RENSEIGNEMENTS DÉTAILLÉS, VEUILLEZ COMMUNIQUER AVEC LE CENTRE DES OPÉRATIONS FRONTALIÈRES AU 613-960-6002.

Annex 2
Due Diligence Report Template

Due Diligence Report

Date

Prepared by:

Table of Contents

Executive Summary

Chronology of Major Events

Due Diligence Report

Objective

CBSA Immigration History of [subject to privacy considerations]

Overview of the Holding Centre

Overview of the

Incident Date: XXX

Analysis –'s Interactions with the CBSA

Analysis –

Conclusion

Appendix 1: Outstanding Investigative Steps

The following steps were undertaken to assist in the writing of this report:

The following steps were not undertaken and are recommended should further investigation be deemed warranted:

Appendix 2: Recommendations

Based on foregoing Due Diligence Report, the following recommendations for the facility and/or region are proposed:

Annex 3
Management Response and Action Plan Template

PREPARATION OF THE MANAGEMENT RESPONSE AND ACTION PLAN (MRAP)

GUIDANCE TO COMPLETE THE MRAP

Overall Management Response

The overall management response should provide regional management's overall reaction to the Due Diligence Report, including findings, conclusions and recommendations. It should be concise (2 paragraphs / 200 words) and allow the reader to assess whether management is in agreement with the results. It also provides an opportunity for management to provide a high level summary of what actions will be taken as a result of the report.

Management Response for each Recommendation (to be included in the report)

A management response is required for each recommendation in the Due Diligence Report. It should state whether management agrees with the recommendation or not. It can provide added context and include a brief summary of the management actions, including key or significant elements of the detailed action plans and dates.

If management disagrees with the recommendation, it should provide the rationale to support this position.

Again, the response should be concise and no longer than 200 words.

Management Action Plan

In addition to the Management Response for each recommendation, provide detailed management action plans that outline the tasks or actions to be taken to address the recommendation. Each action should include a corresponding completion date (year and month). The management action plan provides a baseline that management can use to track progress.

REVIEW OF XXXXX INCIDENT

MANAGEMENT RESPONSE AND ACTION PLAN

OVERALL MANAGEMENT RESPONSE

Text.

RECOMMENDATION 1

The Vice-President of the

MANAGEMENT RESPONSE (TO BE INCLUDED IN THE REPORT)
Text.

MANAGEMENT ACTION PLAN	COMPLETION DATE
Text.	Text

RECOMMENDATION 2

The Vice-President of the

MANAGEMENT RESPONSE (TO BE INCLUDED IN THE REPORT)
Text.

MANAGEMENT ACTION PLAN	COMPLETION DATE
Text.	Text

RECOMMENDATION 3

The Vice-President of the

MANAGEMENT RESPONSE (TO BE INCLUDED IN THE REPORT)
Text.

MANAGEMENT ACTION PLAN	COMPLETION DATE
Text.	Text

Annex 4
Inquest or Public Inquiry Situation Reporting Template

SITUATION REPORT	
Title *(Please note that the content of this template must be modified to suit the incident being reported. Frequency of reporting will be determined by HQ IMWG.)*	
Date :	
Timestamp :	
Key Contact Info :	
CURRENT STATUS	
On Site Report:	
Off Site Report:	
ISSUES / CONSIDERATIONS	
Issues (participation of interest groups/protests:	
Main Issues from proceedings:	
Action Required:	
Lead OPI:	
COMMUNICATIONS	
Media Summary:	
Inquiries (actual & anticipated):	

Social Media	
Additional Communications Activities:	
Next Steps	
Action to be taken:	
Key considerations:	
Assistance Required	
Created by:	
This information is classified Protected A – Only for distribution internal to CBSA. **Ces renseignements sont classifiés Protégé A. Pour distribution interne à l'ASFC seulement.**	

DOCUMENT N^{O}2

LIGNES DIRECTRICES DE LA DIRECTION GÉNÉRALE DES OPÉRATIONS SUR LE PROTOCOLE D'INTERVENTION EN CAS D'INCIDENT GRAVE DANS UN ETABLISSEMENT DE L'ASFC

Table des matières

Préambule

À titre d'employés de l'Agence des services frontaliers du Canada (ASFC), nous jouons tous un rôle important dans la réalisation du mandat de l'Agence, lequel consiste à contribuer au respect des priorités en matière de sécurité nationale et de sécurité publique. Ce document vise à guider la direction de la Direction générale des opérations de l'ASFC quant aux interventions à mettre en œuvre en cas de blessure grave ou de décès survenant sous la garde de l'ASFC et aux signalements afférents. Cette orientation est conforme au mandat et aux objectifs de l'ASFC, laquelle doit réaliser ses activités de manière responsable et transparente.

Pour atteindre ces objectifs et pour donner aux citoyens l'assurance que la sécurité du public, des détenus et du personnel de l'ASFC est notre principale priorité, nous devons intervenir rapidement et de façon uniforme en cas de blessure grave ou de décès d'une personne confiée à la garde de l'ASFC. Nous pouvons y parvenir en faisant ce qui suit :

- ouvrir une enquête lorsqu'une personne sous la garde de l'ASFC subit une blessure grave ou perd la vie dès que des mesures ont été prises pour assurer la sécurité des lieux et des personnes à proximité immédiate du lieu de l'incident;
- examiner et analyser les recommandations formulées dans le rapport et prendre rapidement les mesures nécessaires à la suite de l'incident;
- communiquer les constatations susceptibles de réduire la probabilité qu'un incident semblable se reproduise ou d'en atténuer les conséquences;
- travailler de concert avec l'Unité des services juridiques et l'Administration centrale (AC), en collaborant avec les services policiers, le coroner et tout autre organisme d'enquête dans le cadre de leurs enquêtes sur l'incident tout en veillant à ce que l'ASFC ne se soumette pas, de fait ou en apparence, à la compétence du coroner.

Introduction

Ces lignes directrices doivent être mises en œuvre une fois que les mesures d'intervention immédiate ont été lancées et que le Système de commandement des interventions a été activé. Les mesures d'intervention immédiate comprennent la gestion du lieu où la situation d'urgence est survenue, les urgences médicales, la protection des infrastructures essentielles et l'activation des plans de continuité des opérations, le cas échéant. Une fois que toutes les interventions de gestion d'urgence ont été réalisées, que nos partenaires chargés de l'application de la loi ont terminé leur enquête préliminaire sur les lieux et que la situation est maîtrisée, l'enquête sur l'incident devient notre priorité. Le présent document donne des directives sur l'enquête d'établissement des faits, la documentation de l'incident et la production de rapports sur l'incident.

Le présent document est structuré en fonction des trois mesures distinctes mais connexes à mettre en œuvre en cas d'incident grave :

1. Signalement initial, suivi de la production continue de rapports de situation (étape de la gestion de l'incident)
2. Enquête d'établissement des faits liés aux circonstances de l'incident (étape de l'enquête sur l'incident)
3. Réponse et plans d'action de la direction faisant suite à l'enquête (étape du suivi relatif à l'incident)

Définitions

Rapport après incident – Produit par le Groupe de travail sur l'analyse après incident des directeurs généraux (DG), ce rapport synthétise et analyse le Rapport sur la diligence raisonnable, la Réponse et le plan d'action de la direction régionale, les politiques en vigueur, les exigences en matière de sécurité, les risques pour les détenus et pour les activités de l'Agence et les recommandations antérieures énoncées par le coroner à la suite d'incidents de même nature dans le but de déterminer si des recommandations doivent être formulées et si des mesures doivent être prises sur le plan national.

PGIC (plan de gestion des incidents critiques) – Un incident critique s'entend d'un événement traumatisant d'origine naturelle ou humaine, hors de l'expérience normale, qui peut se produire de façon soudaine ou imprévue et causer un traumatisme émotif ou physiologique. Il peut s'agir d'une situation d'urgence ou d'une catastrophe qui a des répercussions sur le personnel, les installations et les opérations. L'incident critique est susceptible d'avoir des répercussions néfastes et importantes sur l'ensemble des fonctions de l'ASFC en occasionnant des blessures graves ou une mort, d'importants dommages matériels, une atteinte aux services ou l'interruption des opérations frontalières. Le plan de gestion des incidents critiques (PGIC) est un plan officiel qui décrit la manière dont l'organisation doit intervenir en cas d'incident critique. Normalement, les PGIC sont approuvés au niveau des directeurs généraux régionaux. Une description détaillée du PGIC se trouve au

Rapport sur la diligence raisonnable – Produit par le personnel régional, le Rapport sur la diligence raisonnable sert à enregistrer les résultats de l'enquête d'établissement des faits, à examiner les circonstances de l'incident, à signaler les questions qui exigent une enquête plus approfondie et à indiquer et corriger immédiatement les manquements aux normes, aux politiques et aux protocoles en vigueur ou à faire état de tout autre facteur à modifier. L'examen des faits et la production du Rapport sur la diligence raisonnable et de la Réponse et du plan d'action de la direction permettent à l'Agence

de s'assurer que toutes les mesures correctives qui devaient être prises immédiatement ont été mises en œuvre dans les installations ou la région touchées par l'incident.

Examen des faits – Enquête d'établissement des faits relatifs à un incident, menée sur les lieux de l'incident par des membres qualifiés du personnel de la région. L'examen des faits, qui porte sur les circonstances de l'incident, consiste à interroger des membres du personnel de l'ASFC, des entrepreneurs et des employés ne relevant pas de l'ASFC, à examiner tous les documents pertinents, notamment les enregistrements du système de télévision en circuit fermé, et à poursuivre toutes les pistes d'enquête pertinentes. Une fois que le personnel régional a terminé l'enquête d'établissement des faits, la Section des enquêtes relatives aux normes professionnelles de l'AC peut décider de pousser l'enquête plus loin.

L'enquête d'établissement des faits menée par le personnel régional ne remplace pas les enquêtes externes qui peuvent être réalisées parallèlement à celle de l'ASFC par les services policiers, le coroner ou d'autres intervenants.

SCI (système de commandement des interventions) – Système de gestion qui sert à organiser l'ensemble des fonctions, des tâches et du personnel lors d'une intervention d'urgence. Il transforme la confusion propre à une urgence en une intervention bien gérée où les « personnes » sont considérées comme les principaux atouts. Il répond à des questions essentielles telles que « Qui est responsable? » et « Que dois-je faire? ». (1) Une description détaillée des éléments, des rôles et des responsabilités du SCI se trouve au :

Réponse et plan d'action de la direction – Document élaboré par un comité présidé par le directeur régional compétent en réaction aux recommandations énoncées dans le Rapport sur la diligence raisonnable. Ce document doit être remis au Groupe de travail sur la gestion des incidents de l'AC, aux fins d'examen par le Groupe de travail sur l'analyse après incident des DG.

Plan d'action national de la direction – Établi par le Groupe de travail sur l'analyse après incident des DG pour résoudre les enjeux de portée nationale signalés dans le Rapport sur la diligence raisonnable.

CNOF (Centre national des opérations frontalières) – Centre chargé d'assurer la sécurité nationale grâce à la connaissance de la situation, au ciblage, au renseignement et à une réponse tactique coordonnée dans le cadre de la gestion des urgences, des menaces et des enjeux. Il incombe au CNOF d'assurer la surveillance de l'état des activités, d'entretenir et d'améliorer la circulation de l'information entre les partenaires responsables de l'application de la loi dans les régions et nos opérations, d'intervenir en cas d'événements imprévus, de gérer ces événements ainsi que d'examiner et de communiquer les renseignements et les données d'application de la loi ayant trait aux activités frontalières illicites, à la contrebande, à la migration illégale, à la sécurité nationale et au terrorisme.

Incident grave – Tout incident au cours duquel une personne sous la garde de l'ASFC perd la vie ou subit des lésions corporelles graves, que ce soit en raison de causes naturelles, du fait qu'elle s'est elle-même enlevé la vie ou infligé des blessures, lors d'un accident ou par suite de gestes posés par un tiers. Des lésions corporelles graves s'entendent d'un état pathologique qui met la vie en danger.

NEI (notification d'événement important) – Moyen utilisé pour communiquer des renseignements au sein de l'ASFC. Lorsqu'un incident ou un événement atteint le seuil précisé dans les Critères de signalement des événements de l'ASFC, on utilise la NEI pour communiquer le détail de l'incident ou de l'événement au Centre des opérations frontalières (COF). Selon la nature de l'incident ou de l'événement, le COF pourra diffuser ces renseignements plus largement en expédiant une NEI du COF aux personnes dont le nom figure sur une liste de distribution approuvée.

Pouvoirs législatifs pertinents :

Loi sur la protection des renseignements personnels

Loi sur l'immigration et la protection des réfugiés

Code criminel

Loi sur les douanes

Rôles et responsabilités :

A. Intervention et signalement initiaux (étape de la gestion de l'incident)

Dès qu'elle apprend qu'un incident grave est survenu, **la direction des opérations du district ou de la division** prend les mesures suivantes :

1) Appliquer les protocoles en vigueur relativement aux critères de signalement des événements importants et faire rapport du détail de l'événement au COF au moyen d'une notification d'événement important (NEI).
2) Faire le point sur l'incident grave au fur et à mesure qu'il se déroule en faisant rapport au Centre régional des opérations ([CRO] s'il a été mis en service), ou en suivant le processus normal de mise à jour des NEI.
3) Faire intervenir des représentants du programme d'aide aux employés (PAE) et des intervenants spécialisés en gestion du stress lié aux incidents critiques (GSIC), au besoin.

4) Envisager la possibilité de tenir une réunion syndicale-patronale, surtout en cas de refus de travailler éventuels ou réels.
5) Tenir une séance d'information à l'intention du personnel; envisager la possibilité d'informer simultanément les intervenants et les partenaires qui partagent les installations.

Sur réception de la NEI initiale, le **COF** prend les mesures suivantes :

1) Diffuser des renseignements conformément au Processus de gestion des événements.
2) Informer le cadre de service de la Direction générale des opérations, ce dernier ayant peut-être déjà été alerté au moyen d'une NEI envoyée par le personnel sur le terrain.
3) Transmettre une NEI à diffusion limitée aux cadres supérieurs et aux intervenants internes concernés pour leur faire part du détail de l'incident.
4) Mettre la NEI à jour au fur et à mesure que de nouveaux renseignements sont reçus de la région.
5) À la demande du vice-président des Opérations, remplir un rapport sur la fréquence ou des rapports de situation à intervalles prédéterminés.
6) Cesser la production de rapports lorsque l'incident grave est considéré comme terminé et qu'aucun autre renseignement n'est attendu ou requis.

Le Secrétariat de la gestion des enjeux du COF effectue la surveillance des communications internes et externes, des médias, des médias sociaux et des autres sources d'information pertinentes afin d'assurer une meilleure connaissance de la situation et il coordonne l'attribution des tâches et la diffusion des fiches de renseignements sur les enjeux, des chronologies de cas et des autres documents à l'appui.

Après avoir été informé d'un incident grave par le COF, le **vice-président des Opérations** prend les mesures suivantes :

1) Donner des directives quant au moyen à utiliser pour faire rapport sur l'incident et à la fréquence à laquelle les rapports doivent être produits. Normalement, cela consiste en l'établissement d'un point de contact unique, dans la région, aux fins de production des rapports. Le Centre régional des opérations ou le bureau du district ou de la division où l'incident s'est produit ou se produit peut servir de point de contact unique. Le moyen de communication normalement utilisé est la notification d'événement important mais, dans le cas d'événements qui se prolongent, le vice-président des Opérations peut demander à la région de produire un rapport plus détaillé. (Il faudra déterminer si le meilleur moyen à utiliser pour transmettre ces bilans est la NEI, la fiche de renseignements sur les enjeux ou le Rapport de situation quotidien.)
2) Demander à la Direction générale des opérations d'intervenir et de soutenir la région.
3) Diffuser un avis de signalement en cas de fermeture d'un point d'entrée.

4) Informer le directeur général de la Direction de la sécurité et des normes professionnelles (DSNP) de l'incident.

Dès qu'ils sont informés de l'incident, les **vice-présidents des autres directions générales** prennent les mesures suivantes :

1) Se préparer à répondre à des demandes de soutien.
2) Le vice-président de la Direction générale des services intégrés informe l'Avocat général principal de l'ASFC qu'un incident grave est survenu et lui demande du soutien d'ordre juridique.
3) Le vice-président de la Direction générale des services intégrés sollicite le soutien du vice-président de la Direction générale du contrôle et du vice-président de la Direction générale des programmes afin de s'assurer que le Groupe de travail sur l'analyse après incident des DG commence à préparer le rapport après incident et le Plan d'action national de la direction qui y fera suite.

Dès qu'il est informé d'un incident grave, le **directeur général régional** compétent relevant du vice-président des Opérations prend les mesures suivantes :

1) Ordonner le déclenchement du PGIC et du plan de continuité des activités locaux, s'il y a lieu.
2) Demander à la région concernée d'établir une structure de commandement de SCI et de préciser le nom du commandant des interventions et du principal responsable sur les lieux de l'incident. (Il est préférable de confier les fonctions de commandant des interventions et de principal responsable à deux personnes, mais une même personne peut cumuler les deux fonctions pendant une courte période.)
3) Établir un point de contact unique, dans la région, aux fins de la production de rapports. Le Centre régional des opérations ou le bureau du district ou de la division où l'incident s'est produit ou se produit peut servir de point de contact unique. Le moyen de communication normalement utilisé est la notification d'événement important mais, dans le cas d'événements qui se prolongent, la région peut avoir à produire un rapport plus détaillé.
4) À la demande du vice-président des Opérations, créer un moyen et un cadre de communication afin de faire rapport à la haute direction et au COF (c.-à-d. assurer la transmission ininterrompue des NEI). On constitue ainsi un point de contact unique qui fait rapport depuis le Centre régional des opérations ou le bureau du district ou de la division où l'incident s'est produit. Le Rapport de situation détaillé sert à communiquer des renseignements détaillés, selon les directives du directeur général régional. Ce rapport peut servir de document faisant le point sur la situation au moment où l'incident se déroule et lors d'événements subséquents tels que les enquêtes publiques, les enquêtes du coroner ou les audiences. (Voir l'annexe 1 – Modèle de Rapport de situation détaillé.)

5) Assurer l'entière collaboration avec l'organisme chargé de l'application de la loi responsable d'enquêter sur l'incident et nommer un représentant de l'ASFC qui agira comme point de contact permanent de cet organisme.
6) Demander que l'on fasse intervenir les services régionaux de communication, si ce n'est déjà fait.

Dès qu'il est informé du décès d'une personne sous la garde de l'ASFC, **l'adjoint du directeur des services de communication régionaux** prend les mesures suivantes :

> À la demande du directeur général régional, mettre en œuvre le *Protocole de communications publiques — Décès d'une personne en détention*. La mise en œuvre de ce protocole exige notamment de travailler en collaboration avec l'AC dans le but de fournir des renseignements et d'assurer la liaison quant aux activités de communication de nos partenaires et des intervenants, la rédaction de produits de communication, au besoin, et l'obtention de directives et d'approbations.

B. Enquête sur l'incident (étape de l'enquête sur l'incident)

Après l'intervention d'urgence et l'enquête préliminaire menée sur les lieux de l'incident par les responsables locaux de l'application de la loi et dans les sept jours suivant l'incident :

Le **vice-président des Opérations** prend les mesures suivantes :

1) Déterminer s'il faut faire intervenir d'autres régions, directions ou directions générales (p. ex. la région Internationale).
2) De concert avec le directeur général régional, le vice-président des Opérations demande qu'un examen des faits soit réalisé. Le personnel chargé de l'examen des faits produit un rapport sur la diligence raisonnable dans les 60 jours suivant l'incident, cela dans le but d'enregistrer les faits, de déterminer si certaines questions exigent une enquête plus approfondie et de signaler rapidement tout manquement ou écart par rapport aux normes, aux politiques et aux protocoles en vigueur ou en ce qui a trait à l'infrastructure, dans les installations ou la région. Ce rapport ayant une portée strictement régionale, les constatations, recommandations et mesures qui y figurent ne peuvent dépasser le secteur de responsabilité du directeur général régional. (Voir l'annexe 2 – Modèle de Rapport sur la diligence raisonnable.)

Le **directeur général régional** compétent relevant du vice-président des Opérations prend les mesures suivantes :

1) Ordonner au service opérationnel concerné de prendre des mesures immédiates à l'égard de tous les risques imminents connus relatifs aux infrastructures, aux politiques et aux procédures.
2) Commencer à organiser et à préparer les documents en vue d'une enquête, d'une enquête du coroner ou d'une procédure judiciaire; appuyer toutes les enquêtes en cours menées par des tiers (services policiers, coroner ou autres).
3) Travailler en collaboration avec les services de communications de la région et de l'AC afin de répondre aux demandes de renseignements des médias, conformément à toutes les politiques et à tous les protocoles de communication pertinents, notamment la Politique de communication du gouvernement du Canada et le *Protocole de communications publiques — Décès d'une personne en détention* de l'ASFC.
4) Soutenir l'effectif local et nommer des responsables de la gestion des travaux à accomplir dans la division ou le district intéressé. Ces travaux sont notamment les suivants :
    a. Signaler l'incident à l'ambassade ou au consulat concerné, s'il y a lieu, et fournir un point de contact responsable de la gestion en continu des communications.
    b. Faire rapport aux organisations non gouvernementales conformément aux ententes ou aux protocoles d'entente établis (p. ex. la Société canadienne de la Croix-Rouge).
    c. Établir les contacts appropriés ou former des groupes de travail avec des intervenants comme les services correctionnels provinciaux dans le but d'obtenir leurs conseils sur les mesures correctives à mettre en œuvre et de coordonner les interventions opérationnelles et les relations avec les médias.
    d. Commencer à organiser et à préparer les documents en vue d'une enquête, d'une enquête du coroner ou d'une procédure judiciaire.
    e. Demander les conseils des Services juridiques de l'ASFC quant aux renseignements à divulguer aux autorités policières locales, aux services d'enquête du coroner, aux ambassades, aux consulats et à d'autres parties.

Les **vice-présidents des autres directions générales** prennent la mesure suivante :

1) Offrir le soutien nécessaire.

Le **président** prend les mesures suivantes :

1) Demander au vice-président de la Direction générale des services intégrés de réunir les membres du Groupe de travail sur la gestion des incidents (GTGI) de l'AC.

C. Réponse et plan d'action de la direction (étape du suivi relatif à l'incident)

Après avoir rédigé la version provisoire du Rapport sur la diligence raisonnable :

Le **directeur général régional** compétent prend les mesures suivantes :

1) Constituer un comité d'examen régional qui examinera les constatations et les recommandations formulées dans le Rapport sur la diligence raisonnable et approuvera le rapport final dans les 60 jours suivant l'incident.
2) Préparer et mettre en œuvre la réponse et le plan d'action de la direction régionale à l'égard de tous les points soulevés dans le Rapport sur la diligence raisonnable, dans les 75? jours suivant l'incident. (Voir l'annexe 3 – Modèle de Réponse et plan d'action de la direction.)
3) Présenter la version définitive du Rapport sur la diligence raisonnable et la version provisoire de la Réponse et du plan d'action de la direction régionale au Groupe de travail sur la gestion des incidents de l'AC.

Sur réception de la version définitive du Rapport sur la diligence raisonnable et de la Réponse et du plan d'action de la direction régionale de la part du directeur général régional compétent :

Le **vice-président de la Direction générale des services intégrés**, après s'être assuré que l'Unité des services juridiques de l'ASFC a été informée de l'incident dans les plus brefs délais, forme un groupe de travail temporaire sur la gestion des incidents dans les 60 jours suivant l'incident. Ce groupe de travail a les responsabilités suivantes :

- Examiner le Rapport sur la diligence raisonnable et le Rapport après incident.
- Régulièrement vérifier l'avancement des travaux relatifs à la Réponse et au plan d'action de la direction et au Plan d'action national de la direction.
- Coordonner et gérer le processus décisionnel à l'interne.
- Gérer la rédaction des notes d'information destinées au ministre et au président afin que ces derniers puissent faire le point sur les travaux de l'Agence.
- Avec les conseils de l'Unité des services juridiques, gérer l'examen et la rédaction des documents nécessaires aux enquêtes du coroner en envisageant notamment la divulgation licite de renseignements personnels, afin que l'on puisse joindre la famille et les témoins, et d'autres renseignements susceptibles d'être d'intérêt public.
- Gérer l'examen et la rédaction de produits de communication en envisageant notamment la divulgation licite de renseignements personnels dans les cas où l'intérêt public l'emporte sur les conséquences éventuelles de cette divulgation sur la vie privée.
- Veiller à ce que la gestion des travaux à accomplir demeure une priorité pour toutes les personnes concernées à l'AC.

Se reporter au mandat du Groupe de travail sur la gestion des incidents de l'AC (énoncé dans le Document n° 4 de la présente série) et aux modèles afférents.

Le **vice-président des Opérations** prend les mesures suivantes :

1) Superviser, du début à la fin, l'établissement du Rapport sur la diligence raisonnable, des recommandations et du plan d'action de la direction.
2) Participer au GTGI de l'AC et lui fournir une orientation et un soutien constants.
3) Pendant l'enquête du coroner ou l'enquête publique, veiller à ce que le personnel des opérations régionales soit préparé et soutenu et à ce que des rapports soient établis au moins une fois par jour en remplissant le modèle de Rapport de situation relatif à une enquête du coroner ou à une enquête publique (voir l'annexe 4).

Les **vice-présidents de la Direction générale des ressources humaines et de la Direction générale du contrôle** prennent les mesures suivantes :

1) Participer au GTGI ou s'y faire représenter.
2) Fournir une orientation et un soutien constants.
3) Régler les questions de portée régionale et nationale.

Annexe 1
Modèle de Rapport de situation détaillé

Exemple de modèle pour le COF :

Ébauche du rapport de situation
XX mois XXXX; HH:MM HE

TABLE DES MATIÈRES

Remarque : Les sections et le contenu de ce modèle doivent être modifiés en fonction du type d'événement ou d'incident qui fait l'objet du rapport.

Back/Retour

CONTEXTE

Back/Retour

Opérations de l'ASFC

Décrire les conséquences pour les opérations de l'ASFC, faire état des observations du personnel sur le terrain ou du personnel de la région, etc.
Les bilans sur la situation seront principalement fournis dans cette section, au fur et à mesure que d'autres rapports de situation seront rédigés.

Back/Retour

Communications

Peut comprendre des résumés de la couverture médiatique, des demandes de renseignements (reçues ou prévues), des messages à diffuser dans les médias sociaux, d'autres activités de communication, etc.

Back/Retour

Les 24 heures suivantes

Indiquer les prochaines étapes pour la région, le COF, etc.

Indiquer la date et l'heure de publication du prochain rapport de situation.

Back/Retour

CES RENSEIGNEMENTS SONT CLASSIFIÉS « PROTÉGÉ A ». SI VOUS AVEZ DES QUESTIONS OU SOUHAITEZ OBTENIR DES RENSEIGNEMENTS DÉTAILLÉS, VEUILLEZ COMMUNIQUER AVEC LE CENTRE DES OPÉRATIONS FRONTALIÈRES AU 613-960-6002.

THIS INFORMATION IS CLASSIFIED PROTECTED A. IF YOU HAVE ANY QUESTIONS OR FOLLOW UP REQUESTS FOR DETAILED INFORMATION, PLEASE CONTACT THE BORDER OPERATIONS CENTRE AT 613-960-6001.

Rapport sur la diligence raisonnable

Date :

Établi par :

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Aperçu du centre de surveillance

Aperçu de

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Analyse – Interactions avec l'ASFC

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Conclusion

Appendice 1 : Étapes de l'enquête non réalisées

Les mesures suivantes ont été prises pour faciliter la rédaction de ce rapport :

Les mesures suivantes n'ont pas été prises et il est recommandé de les mettre en œuvre si l'on juge nécessaire de poursuivre l'enquête :

Appendice 2 : Recommandations

Compte tenu du Rapport sur la diligence raisonnable qui précède, nous formulons les recommandations suivantes à l'intention des responsables de l'installation ou de la région :

Annexe 3
Modèle de réponse et de plan d'action de la direction

ÉLABORATION DE LA RÉPONSE ET DU PLAN D'ACTION DE LA DIRECTION (RPAD)

CONSIGNES POUR L'ÉLABORATION DE LA RPAD

Réponse générale de la direction

Cette réponse doit décrire la réaction générale de la direction régionale à l'égard du Rapport sur la diligence raisonnable, y compris les constatations, les conclusions et les recommandations. Elle doit être concise (deux paragraphes/200 mots) et permettre au lecteur de déterminer si la direction accepte les résultats. Elle doit aussi permettre à la direction de fournir un résumé de haut niveau des mesures qui seront prises par suite du rapport.

Réponse de la direction à chaque recommandation (à inclure dans le rapport)

Une réponse de la direction est requise pour chaque recommandation formulée dans le Rapport sur la diligence raisonnable. Elle doit indiquer si la direction accepte la recommandation. Elle peut fournir du contexte et comprendre un bref sommaire des mesures prises par la direction, y compris les éléments importants et les dates clés des plans d'action détaillés de la direction.

Si la direction n'accepte pas la recommandation, elle doit justifier sa position.

Une fois encore, la réponse de la direction doit être concise et ne pas excéder 200 mots.

Plan d'action de la direction

En plus de la réponse de la direction à chaque recommandation, veuillez fournir les plans d'action détaillés de la direction décrivant les tâches qui seront effectuées ou les mesures qui seront prises pour donner suite aux recommandations. Chaque mesure doit être accompagnée d'une échéance (année et mois). Le plan d'action de la direction fournit un point de référence dont la direction peut se servir pour faire le suivi des progrès.

EXAMEN DE L'INCIDENT XXXXX

RÉPONSE ET PLAN D'ACTION DE LA DIRECTION

RÉPONSE GÉNÉRALE DE LA DIRECTION

Texte.

RECOMMANDATION 1

Le vice-président de la Direction générale

RÉPONSE DE LA DIRECTION (À INCLURE DANS LE RAPPORT)
Texte.

PLAN D'ACTION DE LA DIRECTION	DATE D'ACHÈVEMENT
Texte.	Texte

RECOMMANDATION 2

Le vice-président de la Direction générale

RÉPONSE DE LA DIRECTION (À INCLURE DANS LE RAPPORT)
Texte.

PLAN D'ACTION DE LA DIRECTION	DATE D'ACHÈVEMENT
Texte.	Texte

RECOMMANDATION 3

Le vice-président de la Direction générale

RÉPONSE DE LA DIRECTION (À INCLURE DANS LE RAPPORT)
Texte.

PLAN D'ACTION DE LA DIRECTION	DATE D'ACHÈVEMENT
Texte.	Texte

Annexe 4

Modèle de Rapport de situation relatif à une enquête du coroner ou à une enquête publique

RAPPORT DE SITUATION	
Titre *(Veuillez noter que le contenu de ce modèle doit être modifié en fonction de l'événement qui fait l'objet du rapport.) La fréquence des rapports sera déterminée par le GTGI de l'AC.)*	
Date	
Horodatage	
Coordonnées de la personne-ressource	
ÉTAT ACTUEL	
Rapport d'examen sur les lieux	
Rapport d'examen hors des lieux	
ENJEUX ET POINTS À CONSIDÉRER	
Enjeux (participation de groupes d'intérêt ou de protestataires)	
Principaux enjeux découlant de la procédure	
Mesures à prendre	
Bureau de première responsabilité responsable	
COMMUNICATIONS	

Résumé de la couverture médiatique	
Demandes de renseignements (reçues ou prévues)	
Médias sociaux	
Activités de communication supplémentaires	
Prochaines étapes	
Mesures à prendre	
Principaux points à prendre en considération	
Aide nécessaire	
Rempli par	
Ces renseignements sont classifiés « Protégé A ». Pour distribution interne à l'ASFC seulement.	

18 April 2016

DOCUMENT 3

Terms of Reference for the

DG After-Incident Review Working Group (AIRWG)

To Respond to a Death or Serious Injury in CBSA Custody

Mandate

DG-Level post incident review working group, entitled the DG After Incident Review Working Group (DG-AIRWG) to be struck upon notification of a serious injury or death in CBSA custody to:

- Review Due Diligence Report drafted by the relevant Region;
- To conduct any secondary reviews deemed necessary;
- To prepare an "After Incident Report" for review by the VP-chaired HQ Incident Management Working Group (HQ-IMWG) and National Management Action Plan.
- Assist in the preparation of briefing notes, materials and communications products as may be required to support the HQ-IMWG; and,
- Champion any actions required at a national level.

This working group will meet on an "as needed" basis with a view to reporting to the HQ-IMWG as needed.

Membership

Co-Chairs: DG, Security and Professional Standards, Comptrollership
Executive Director, Enforcement and Intelligence, Programs

Members: Relevant Regional Director General
Relevant Regional Director
Counsel assigned to the case
Other Directors/Director Generals as needed

Secretariat support to be provided by EIPD, Programs Branch to the Chairs, including the role of preparing any necessary documents and reports for the consideration of the DG-AIRWG and HQ-IMWG, such as the DG-AIRWG National Management Action Plan??? or the After Incident Report.

Initiation and Operation of the Working Group

- Upon notification of a significant incident involving death in custody, the DG-AIRWG will be immediately struck with the participation of the RD and/or RDG of the implicated region.
- Upon receipt of the Due Diligence Report from the region, it is the responsibility of the DGAIRWG to review that report and ensure completeness of the record of the incident. Review and feedback from the AIRWG of the Due Diligence report should be completed within 30 days and final approval should be given prior to the development of the Management Response and Action Plan.
    - This DG committee would identify whether specialised lines of support or investigation are required, and would assist with acquisition of and direct work of special investigators.
- Once the Due Diligence Report is deemed complete by the DG AIRWG, it is the responsibility of the DG AIRWG to assess whether appropriate policies, guidelines and directives have been adhered to in relation to the incident and what remedies, if any, may be required. This assessment would be delivered in the form of an After Incident Report.
- The After Incident Report is to be presented to the HQ IMWG for review, consideration and direction on a timely basis, not greater than 90 days from the date of the incident.
- To achieve these objectives, the working group will meet at a frequency as is necessary to swiftly achieve its objectives.

18 April 2016

Template for National Management Action Plan

NATIONAL MANAGEMENT ACTION PLAN

OVERALL MANAGEMENT RESPONSE

RECOMMENDATION 1

MANAGEMENT RESPONSE

MANAGEMENT ACTION PLAN	COMPLETION DATE

18 April 2016

RECOMMENDATION 2

MANAGEMENT RESPONSE

MANAGEMENT ACTION PLAN	

18 avril 2016

DOCUMENT N° 3

Mandat du

Groupe de travail sur le rapport après incident des DG

En cas d'un décès ou d'une blessure grave en établissement

Mandat

Le Groupe de travail sur le rapport après incident des DG est convoqué dès qu'il est avisé d'une blessure grave ou d'un décès se produisant sous la garde de l'ASFC pour :

- examiner le rapport sur la diligence raisonnable rédigé par la région concernée;
- réaliser tout examen secondaire jugé nécessaire;
- produire un « rapport après incident » aux fins de son examen par le Groupe de travail sur la gestion des incidents (GTGI) de l'AC, qui est présidé par le vice-président (VP), de même qu'un plan d'action de gestion national;
- contribuer à la production de notes d'information, de documents et de produits de communication, au besoin, qui appuieront le GTGI de l'AC;
- agir comme champion de toute mesure nécessaire, le cas échéant, à l'échelle nationale.

Ce groupe de travail se réunira « au besoin » dans le but de faire rapport, s'il y a lieu, au GTGI de l'AC.

Membres

Coprésidents :	Directeur général (DG), Direction de la sécurité et des normes professionnelles, Direction générale du contrôle Directeur exécutif, Direction des programmes d'exécution de la loi et du renseignement, Direction générale des programmes
Membres :	Directeur général régional concerné Directeur régional concerné Avocat assigné au dossier Autres directeurs et directeurs généraux, au besoin

La Direction des programmes d'exécution de la loi et du renseignement de la Direction générale des programmes assure les services de secrétariat pour les présidents, ce qui comprend notamment la production des documents et rapports nécessaires, s'il y a lieu, aux fins de leur examen par le Groupe de travail sur l'analyse après incident des DG et

le GTGI de l'AC, comme le plan d'action de gestion national du Groupe de travail sur l'analyse après incident des DG ou le rapport après incident.

Mise sur pied et fonctionnement du Groupe de travail

- Lorsqu'il est avisé d'un incident grave impliquant un décès se produisant sous la garde de l'ASFC, le Groupe de travail sur le rapport après incident des DG est convoqué immédiatement, et le directeur général régional ou le directeur régional concerné est présent à la réunion.
- À la suite de la réception du rapport de diligence raisonnable de la région concernée, il incombe au Groupe de travail sur l'analyse après incident des DG de l'examiner et de voir à ce que le rapport après incident soit exhaustif. Le Groupe de travail sur l'analyse après incident des DG dispose de 30 jours pour examiner le rapport de diligence raisonnable et présenter une rétroaction. L'approbation définitive doit se faire avant l'élaboration du plan d'action et de la réponse de la direction.
    - Ce comité du DG doit déterminer si des enquêtes ou des niveaux de soutien spécialisés s'imposent et contribuer à l'acquisition des services d'enquêteurs spécialisés et à l'exécution de travaux directs de leur part.
- Une fois que le rapport de diligence raisonnable est jugé exhaustif par le Groupe de travail sur le rapport après incident des DG, il incombe à ce dernier d'évaluer la question à savoir si les politiques, les lignes directrices et les directives pertinentes ont été respectées par rapport à l'incident, et de déterminer les solutions qui pourraient s'imposer, s'il y a lieu. Cette évaluation prendrait la forme d'un rapport après incident.
- Le rapport après incident doit être présenté au GTGI de l'AC aux fins de son examen, de son étude et de l'établissement d'une orientation en temps utile, au plus tard 90 jours après la date de l'incident.
- Pour atteindre ces objectifs, le groupe de travail se réunira à une fréquence jugée nécessaire afin d'y parvenir rapidement.

18 avril 2016

Modèle de plan d'action de gestion national

PLAN D'ACTION DE GESTION NATIONAL

RÉPONSE GÉNÉRALE DE LA DIRECTION

RECOMMANDATION 1

RÉPONSE DE LA DIRECTION

PLAN D'ACTION DE LA DIRECTION	DATE D'ACHÈVEMENT

18 avril 2016

RECOMMANDATION 2

RÉPONSE DE LA DIRECTION

PLAN D'ACTION DE LA DIRECTION	

Record of Decisions

Executive Committee – Ad hoc

June 29, 2016

Attendees

Ms. Linda Lizotte-Macpherson (President)
Ms. Nada Semaan
Mr. Martin Bolduc
Mr. Maurice Chénier
Mr. Jean-Stéphen Piché
Mr. Denis R. Vinette
Ms. Christine Walker
Ms. Caroline Weber
Mr. Peter Hill
Mr. Louis-Paul Normand
Mr. Tom Saunders
Mr. Colin Boyd (for Mr. Robert Mundie)
Ms. Dena Palamedes
Mr. Marc Raider

Observers

Ms. Cindy Bouchard
Mr. Joey Mackenzie
Ms. Mélanie Maisonneuve

Ms. Tambrae Knapp (for item #3)
Mr. John Pinsent (for item #3)
Mr. Chris Beall (for item #3)
Ms. Leslie Soper (for item #4)
Mr. Pierre Giguère (for item #4)
Mr. Patrick Crocco (for item #4)
Mr. Marc Thibodeau (for item #4)

Absent

Ms. Caroline Xavier
Mr. Robert Mundie
Ms. Gail Gosselin

Item #1: President's Debrief **Sponsor(s)**: President **Purpose for Coming to Committee**: Information **Presenter(s)**: President
Action Item(s): • None
Decision(s) Taken: • None
Item #2: Border Management Forecast **Sponsor(s)**: Vice-President, Operations Branch **Purpose for Coming to Committee**: Information **Presenter(s)**: Associate Vice-President, Operations Branch
Action Item(s): • None

Decision(s) Taken: • None
Item #3: Follow-Up – Capital Plan **Sponsor(s)**: Vice-President, Controllership Branch **Purpose for Coming to Committee**: Decision **Presenter(s)**: Vice-President, Controllership Branch
Action Item(s): • The Comptrollership Branch with support from the Programs and Operations Branches is to return by the end of July to the Executive Committee (EC) with an overall picture of CBSA Ports of Entry (POE) and a strategy that identifies current POE state of repair and replacement plans and potential sources of funds.
Decision(s) Taken: • EC approved funding for streams B and C as proposed,
Item #4: Death in Custody Communications Protocol **Sponsor(s)**: Executive Vice President **Purpose for Coming to Committee**: Decision **Presenter(s)**: Ms. Caroline Weber
Action Item(s): • None
Decision(s) Taken: • EC approved option 2 and the proposed next steps.
Item #5: Round Table **Sponsor(s)**: All **Purpose for Coming to Committee**: Information **Presenter(s)**: All
Action Item(s): • None
Decision(s) Taken: • None

Approved by the members of the Executive Committee – Look Ahead on XX.

Compte rendu des décisions

Réunion spéciale du Comité exécutif

Le 29 juin 2016

Présents

M^me^ Linda Lizotte-MacPherson (présidente)
M^me^ Nada Semaan
M. Martin Bolduc
M. Maurice Chénier
M. Jean-Stéphen Piché
M. Denis R. Vinette
M^me^ Christine Walker
M^me^ Caroline Weber
M. Peter Hill
M. Louis-Paul Normand
M. Tom Saunders
M. Colin Boyd (pour M. Robert Mundie)
M^me^ Dena Palamedes
M. Marc Raider

Observateurs

M^me^ Cindy Bouchard
M. Joey Mackenzie
M^me^ Mélanie Maisonneuve

M^me^ Tambrae Knapp (pour point n° 3)
M. John Pinsent pour point n° 3)
M. Chris Beall (pour point n° 3)
Ms. Leslie Soper (pour point n° 4)
M. Pierre Giguère (pour point n° 4)
M. Patrick Crocco (pour point n° 4)
M. Marc Thibodeau (pour point n° 4)

Absents

M^me^ Caroline Xavier
M. Robert Mundie
M^me^ Gail Gosselin

Point n° 1 : Présidente : Mise au point **Responsable(s)** : Présidente **But de la présentation devant le Comité** : Information **Présentateur(s)** : Présidente
Mesure(s) de suivi • Aucune
Décision(s) prise(s) • Aucune
Point n° 2 : Prévisions de la gestion frontalière **Responsable(s)** : Vice-présidente, Direction générale des opérations **But de la présentation devant le Comité** : Information **Présentateur(s)** : Vice-présidente associé, Direction générale des opérations
Mesure(s) de suivi • Aucune

Décision(s) prise(s) • Aucune
Point n° 3 : Suivi – Plan d'immobilisation **Responsable(s)** : Vice-présidente, Direction générale du contrôle **But de la présentation devant le Comité** : Décision **Présentateur(s)** : Vice-présidente, Direction générale du contrôle
Mesure(s) de suivi • Avec l'aide de la Direction générale des programmes et la Direction générale des opérations, la Direction générale du contrôle doit brosser un portrait global des bureaux d'entrée de l'ASFC et préparer une stratégie indiquant l'état actuel des bureaux, les plans de remplacement et de réparation et d'éventuelles sources de financement et venir présenter le tout au Comité exécutif (CE) d'ici la fin juillet.
Décision(s) prise(s) • Le CE approuve le financement pour les volets B et C tel qu'il est proposé,
Point n° 4: Protocole communicationnel l'hors d'un décès en détention **Responsable(s)** : Première Vice-présidente **But de la présentation devant le Comité** : Décision **Présentateur(s)** : Mme. Caroline Weber
Mesure(s) de suivi • Aucune
Décision(s) prise(s) • Le CE approuve l'option 2 ainsi que les prochaines étapes proposées.
Point n° 5 : Tour de table **Responsable(s)** : Tous **But de la présentation devant le Comité** : Information **Présentateur(s)** : Tous
Mesure(s) de suivi • Aucune
Décision(s) prise(s) • Aucune

Approuvé par les membres du Comité exécutif – Aperçu le XX.

Canada

Protocols for Responding to Death or Serious Injury in Custody

Presentation for Executive Committee

April 21, 2016

Canada

Purpose and Outline

- To seek direction regarding a proposed protocol to response to deaths or serious injury in CBSA custody or control.

Outline

- Context
- Objectives
- Proposed approach

Context

- Deaths or injuries in CBSA custody or control happen very infrequently (11 out of 98,722 detainees over 12 years), but even one is cause for reflection and concern.
- We need a process that helps us to analyze and take any corrective actions necessary, quickly, after a death or serious injury in custody.
- We need to agree on an approach and a process that helps us to manage through inquests conducted by provincial governments, recognizing that the Government of Canada does not attorn to other governments.

Recent Deaths in Custody Requiring Inquests

- Shawn Cole, December 26, 2012, died of medical causes, Toronto East Detention Centre.
- Lucia Dominga Vega Jimenez, December 28, 2013 suicide at the British Columbia Immigration Holding Centre.
- Joseph Charles Todd Dunn, December 27, 2014, suicide at the Niagara Detention Centre.
- Abdurahman Hassan, June 11, 2015, cause of death is under investigation, Central East Correctional Centre, Lindsay Ontario
-
- Francisco Javier Romero Astorga, March 13, 2016, died of medical causes, Maplehurst Correctional Complex.

Objectives of Approach

- To provide rapid and coherent responses to a serious incident resulting in injury or death to a person in CBSA custody or control.
- To assure the public that the safety of the public, detainees, and staff are a top priority of the CBSA.
- Ensure HQ is informed and
  - can review the regional review and action items to assess completeness and need for any further action, and
  - can incorporate the findings of the regional review into considerations of our operations nationally.
- Ensure continuity and engagement of management, from incident review through an inquest and follow-up actions.
- Ensure that the Minister and senior executives are informed, and that the Agency has taken any necessary actions and is ready to respond to inquiries quickly.
- Ensure the continuity of operations and service delivery concurrent to investigation and follow-up.
- Ensure Legal Services is engaged at the earliest opportunity.

Proposed Approach: A three-tier approach (Annex A)

- Regional team, Fact-finding and Due Diligence Report (Annex B)
  - To mobilize resources to respond to the death or injury.
  - Report to be completed as quickly as possible after the death or injury in order to document the incident and to quickly identify any actions that should be taken immediately in the region.
- HQ-DG level After-Incident Review Working Group (Annex C)
  - Reviews the regional fact-finding report and assess completeness and any need for further review, and provides any additional observations or recommendations for national program.
- HQ Incident Management Working Group – VP level (Annex D)
  - Reviews the reports and monitors follow-up.
  - Provides updates to President/Minister.
  - Monitors media and coordinates up to, during, and after inquest.
  - Coordination CBSA response and approach if CBSA witnesses or documents are requested by Coroner

Incident and Investigation Process

Incident Management Phase → **Incident Investigation Phase** → **Incident Follow-up Phase**

Incident

Day 1

Lead RDG
- Activate Local CIMP and BCP if required
- Activate ICS model and Regional Ops Ctr
- Ensure continued SEN reporting
- Engage Regional Comms (with support from NHQ Comms)
- Support on scene 3rd party investigations
- Return to normal ops as soon as practicable

VP Ops
- Direct operational response and national reporting (Sitreps, Issue Fact sheets, etc.)
- Direct Ops Branch engagement, support to region
- Issue Border Alert if POE closed
- Inform Departmental Security Officer (DSO)

VP CAB and DG Comms
- Ensure protocol is followed and message is posted.
- Advise CBSA's Senior General Counsel

Other VPs
- Be prepared for requests for support

Day 1 – Day 15

Lead RDG
- Conduct Fact Finding Review from regional resources (if no SPSD investigations will take place)
- Produce Due Diligence Report
- Support local workforce
- Support ongoing 3rd party investigations(Police, Coroner, etc)
- Address any issues relating to officer/client safety

VP Ops
- Direct Fact Finding Review
- Seek engagement of DG SPSD and other DGs to conduct or support Fact Finding Review
- Make recommendation to President to convene the Incident Management Working Group(IMWG)

VP Comptrollership
- Provide DG SPSD and other DGs as appropriate to support VP Ops Fact Finding Review.

Other VPs
- Support as required

Day 15 – on-going

Lead RDG
- Convene Regional Review Committee to finalize Due Diligence Report
- Prepare Management Response and Action Plan

VP Ops
- Support the IMWG from within Ops

VP CAB
- Convene IMWG
- Task DG After Incident Review (AIR) Working Group to produce AIR, and National Management Action Plan to AIR
- Coordinate national response (Policy, Legal, ATIP, HR, Comms, etc)
- Lead CBSA participation for follow up on public inquiries, inquests, audits, etc.
- Review and approve AIR and National MAP produced by DG sub committee
- Brief President and Minister on an ongoing basis

Other VPs
- Participate in or provide representatives for the IMWG
- Bring closure to national level matters
- Make recommendations for implementation

Discussion and Next Steps

- Seeking discussion and approval of the approach and documents provided.
- If or when approved, these documents will be posted on Atlas, and a message will be sent to all staff.
- PB to develop and bring forward for discussion and approval a policy to address return of remains and funeral expenses

Protocoles d'intervention en cas de décès ou de blessure grave en établissement

Présentation à l'intention du Comité exécutif

Le 21 avril 2016

Objectif et aperçu

- Obtenir des directives concernant un protocole d'intervention proposé en cas de décès ou de blessures graves de personnes sous la garde ou le contrôle de l'ASFC.

Aperçu

- Contexte
- Objectifs
- Approche proposée

Contexte

- Les décès ou les blessures de personnes sous la garde ou le contrôle de l'ASFC se produisent très rarement (10 détenus sur 98 722 en 12 ans), mais un seul incident est source de réflexion et de préoccupation.
- Nous avons besoin d'un processus qui nous aide à analyser et à prendre toute mesure corrective nécessaire rapidement, après le décès ou la blessure grave de personnes sous la garde ou le contrôle de l'ASFC.
- Nous devons convenir d'une approche et d'un processus qui nous aideront à gérer les enquêtes réalisées par les gouvernements provinciaux puisque le gouvernement du Canada ne reconnaît pas la compétence juridictionnelle des autres gouvernements.

Décès récents survenus en établissements qui ont donné lieu à des enquêtes

- Shawn Cole, le 26 décembre 2012, décédé de causes médicales, Centre de détention de l'Est de Toronto.
- Lucia Dominga Vega Jimenez, le 28 décembre 2013, suicide au Centre de surveillance de l'Immigration de la Colombie-Britannique.
- Joseph Charles Todd Dunn, le 27 décembre 2014, suicide au Centre de détention de Niagara.
- Abdurahman Hassan, le 11 juin 2015, enquête sur la cause de décès est en cours, Centre correctionnel du Centre-Est à Lindsay en Ontario.
-
- Francisco Javier Romero Astorga, le 13 mars 2016, décédé de causes médicales, Complexe correctionel Maplehurst

Objectifs de l'approche

- Fournir des mesures d'intervention rapides et cohérentes en cas d'incident grave causant des blessures ou la mort à des personnes sous la garde ou le contrôle de l'ASFC.
- Assurer au public que la sécurité du public, des détenus et des employés constituent une priorité pour l'ASFC.
- Veillez à ce que l'AC soit informée et qu'elle puisse :
  - Passer en revue l'examen régional et les mesures de suivi afin d'évaluer l'exhaustivité de l'information et de déterminer s'il faut prendre des mesures supplémentaires.
  - Intégrer les conclusions de l'examen régional dans les facteurs à prendre en considération dans le cadre des opérations à l'échelle nationale.
- Assurer la continuité et la mobilisation de la direction, lors de l'examen de l'incident, de l'enquête et des mesures de suivi.
- Veiller à ce que le ministre et les cadres supérieurs soient informés, que l'Agence a pris toutes les mesures nécessaires et qu'elle est prête à répondre aux demandes de renseignements rapidement.
- Assurer la continuité des opérations et de la prestation des services tout au long de l'enquête et des mesures de suivi.
- Veiller à ce que les Services juridiques soient consultés aussi tôt que possible.

Approche proposée : une approche en trois volets (annexe A)

- Équipe régionale, recherche des faits et rapport sur la diligence raisonnable (annexe B)
  - Préparer les ressources à intervenir en cas de blessure ou de décès.
  - Le rapport doit être préparé dès que possible après le décès ou la blessure afin de documenter l'incident et de déterminer rapidement toutes les mesures qui devraient être prises immédiatement dans la région.
- Groupe de travail sur le rapport après l'incident formé de DG de l'AC (annexe C)
  - Examiner le rapport régional sur la recherche des faits, évaluer l'exhaustivité de l'information, déterminer s'il faut effectuer un examen plus poussé, faire part des observations ou des recommandations supplémentaires à l'égard du programme national.
- Groupe de travail sur la gestion des incidents formé de VP de l'AC (annexe D)
  - Examiner les rapports et surveiller les mesures de suivi.
  - Fournir des mises à jour à la présidente/au ministre.
  - Surveiller les médias et coordonner le travail avant, pendant et après l'enquête.
  - Coordonner l'intervention de l'ASFC et la procédure à suivre si le coroner demande à parler aux témoins ou à voir des documents de l'ASFC.

Incident et processus d'enquête

Incident

Phase de gestion de l'incident

Jour 1

DGR responsable
- Mettre en œuvre le PGIC et le PCO locaux, le cas échéant
- Mettre en œuvre le modèle du SCI et le centre régional des opérations
- Veiller au suivi des AEI
- Mobiliser les communications régionales (avec l'aide des communications de l'AC)
- Soutien sur place lors d'enquêtes réalisées par des tiers
- Retour aux opérations normales dès que possible

VP Opérations
- Intervention opérationnelle directe et rapports à l'échelle nationale (rapports de situation, fiches de renseignements sur les enjeux, etc.)
- Mobilisation directe de la Direction générale des opérations, soutien à la région
- Diffusion d'une alerte frontalière si le PDE est fermé
- Informer l'agent de sécurité du ministère (ASM)

VP DGSI et DG Communications
- Veiller au respect du protocole et à la diffusion du message.
- Conseiller l'avocat général principal de l'ASFC

Autres VP
- être préparé pour les demandes de support

Phase de l'enquête sur l'incident

Jour 1 au jour 15

DGR responsable
- Effectuer une recherche des faits avec l'aide des ressources régionales (si la DSNP n'effectue pas d'enquête)
- Produire le rapport sur la diligence raisonnable
- Appuyer la main-d'œuvre locale
- Appuyer les enquêtes réalisées par des tiers (police, coroner, etc.)
- Régler les enjeux liés à la sécurité des agents et des clients

VP Opérations
- Diriger la recherche des faits
- Obtenir la mobilisation du DG de la DSNP et des autres DG dans le cadre de la réalisation de la recherche des faits
- Formuler une recommandation à la présidente relativement à la convocation du Groupe de travail sur la gestion des incidents (GTGI)

VP Contrôle
- Le cas échéant, assurer la participation du DG de la DSNP ainsi que d'autres DG dans le cadre de la recherche des faits réalisée par le VP des Opérations.

Autres VP
- Offrir de l'aide, le cas échéant

Phase de suivi sur l'incident

Jour 15 – continu

DGR responsable
- Convoquer le comité d'examen régional pour terminer le rapport sur la diligence raisonnable
- Préparer la Réponse et plan d'action de la direction

VP Opérations
- Appuyer le GTGI depuis les Opérations

VP DGSI
- Convoquer le GTGI
- Attribuer des tâches au Groupe de travail sur l'analyse après incident (AAI) formé de DG en vue de la production d'un plan d'action pour l'AAI et d'un plan d'action de gestion national sur l'AAI
- Coordonner l'intervention à l'échelle nationale (politique, juridique, AIPRP, RH, Communications, etc.)
- Diriger la participation de l'ASFC dans le cas du suivi aux demandes de renseignements du public, des enquêtes, des vérifications, etc.
- Examiner et approuver les AAI et les PAG à l'échelle nationale produits par des sous-comités formés de DG
- Informer la présidente et le ministre de façon continue

Autres VP
- Participer ou envoyer des représentants au GTGI
- Clore les dossiers qui ont une incidence à l'échelle nationale
- Formuler des recommandations quant à la mise en œuvre

Discussion et prochaines étapes

- Discussion et approbation de l'approche et des documents fournis.

- Si et quand ils sont approuvés, ces documents seront affichés sur Atlas et un message sera envoyé à tous les employés.

- La Direction générale des programmes doit préparer une politique sur les dépenses relatives au rapatriement des personnes décédées et aux funérailles

DOCUMENT 1
OVERARCHING GUIDELINES FOR RESPONDING TO A SERIOUS INCIDENT IN CBSA CUSTODY OR CONTROL
DRAFT: 18 April 2016

Policy Objective:

Rapid and coherent responses to a serious incident resulting in injury or death to a person in CBSA custody or control are required to ensure responsibility, accountability and transparency within CBSA, and to assure the public that the safety of the public, detainees, and staff are a top priority of the CBSA, by:

- Reviewing and analyzing regional reports and taking appropriate action following an incident;

Sharing any findings that could reduce the risk of a similar incident occurring in the future.**Pertinent Legislative Authorities:**

Privacy Act
Immigration and Refugee Protection Act
Criminal Code of Canada
Customs Act

Roles and Responsibilities:

1. The relevant Regional Director General reporting to the Vice-President of Operations must:

- Ensure full cooperation with the appropriate law enforcement organization assigned to investigate the incident.
- Assign people in the appropriate division to:
    - Review the physical space if the incident occured at a CBSA location, in consultation with CBSA Security;
    - Liaise with local officials (police, embassies, consulates, etc.) and third parties (NGOs, contractors, etc.);
    - Prepare a "Due Diligence Report" – to be finalized within 30 days of the incident - to record the facts and rapidly identify any immediate breaches of existing standards, policies or protocols;
    - Prepare a "Management Response and Action Plan" in response to any items identified in the fact-finding "Due Diligence Report".
    - Prepare a "Summary Report" to share with the Office of the Coroner, when requested.
- Prepare materials for any investigation, inquest, or court proceeding, subject to the advice of Legal Services in the context of interjurisdictional and intergovernmental authorities and immunity principles. which require a nuanced approach to participation by federal government departments and agencies in provincial proceedings.

- Work with HQ Communications to respond to media enquiries, using all relevant policies and protocols.

Refer to the "Operations Branch Guidelines for Responding to a Serious Incident in CBSA Custody" ("Document 2" in this series), and associated templates.

2. The relevant Director General in Programs Branch, and the Director General, Security and Professional Standards (Comptrollership Branch) will convene and co-chair a temporary committee to review the fact-finding "Due Diligence Report" prepared by Operations to: validate the recommendations; determine whether additional actions, investigations, or recommendations are necessary; assess the implications of the findings for national programs, policies and procedures; develop recommendations if appropriate and develop a National Work Plan; and summarize all of this in an "After Incident Report".

    - The committee will determine whether there is a need for further investigation by Professional Standards, or to engage a third party to review CBSA operations.

Refer to the Terms of Reference for the Director Generals' After-Incident Review Working Group ("Document 3" in this series), and associated templates.

3. The Vice-President, Corporate Affairs will ensure that Legal Services is aware of the incident, and convene a temporary incident management working group within 30 days of the incident to:
    - Review the Due Diligence Report, the Management Response and Action Plan and the After Incident Report.
    - Review on a regular basis the progress on the Management Response and Action Plan and the National Work Plan.
    - Coordinate and manage internal decision-making.
    - Manage the preparation of briefing notes for the Minister and the President, to provide updates on the work of the Agency.
    - With the advice of Legal Services, manage the review and preparation of materials for any inquest, including consideration of the lawful release of personal information for the purpose of contacting family and witnesses and other releases that might be in the public interest.
    - Manage the review and preparation of communications products, including consideration of the lawful release of personal information when the public interest outweighs the potential privacy impact.
    - Ensure that management of the work remains a priority for all involved at headquarters.

Refer to the Terms of Reference for the HQ Incident Management Working Group ("Document 4" in this series), and associated templates.

COMMUNICATIONS GUIDELINES FOR INITIAL RESPONSE TO A DEATH OR SERIOUS INJURY IN THE CUSTODY OR CONTROL OF THE CBSA

Communications Objective:

To outline the communications process for the initial response to a serious incident resulting in injury or death to a person in CBSA custody or control, including the dissemination of a **news release** within 6 hours of notification from authorities, and completion of an **8(2)(m)(i)** (of the *Privacy Act*) analysis within 72 hours of posting the news release.

Initial Response and Reporting:

Upon being notified of a serious incident (by Operations):

(Note that timelines may vary within the first six hours based on available information, consultations and approvals)

1) **00:00-00:30:** It is implied in this process that OPS (BOC) will notify the DG Comms immediately upon an incident resulting in injury or death to a person in CBSA custody or control. Within 30 minutes or less of OPS (BOC) notification, the HQ Director General (DG) Communications will confirm that HQ Communications is actively engaged by advising the following:
    a. President's Office (PO)
    b. Executive-Vice President's Office (EVPO)
    c. Vice-President Corporate Affairs Branch (VP CAB)
    d. Public Safety Communications (PS)
    e. Minister's Office (MINO)
    f. Privy Council Office (PCO)
    g. Cc: to Vice-President Programs (VP PROG), Vice-President Operations (VP OPS) Branch, Vice-President Comptrollership Branch (VP CB), relevant Regional Director General (RDG), Executive Director (ED) Communications, Director Public Affairs and Strategic Communications (DPASC), relevant A/Director Regional Communications (A/Dir Comms), HQ Public Affairs Manager Operations, HQ Manager Media Relations, HQ Chief Privacy Officer.
2) **00:00-00:30:** Standby Notification is issued to all relevant HQ Communications and Translation services personnel who will be involved in developing, coordinating and issuing communications products, including:
    a. Translation services
    b. Marketwired

   c. Web / eComms / Social media
   d. Public Affairs unit responsible for President's national e-mail account should a national all-staff message be required

3) **00:00 – 1 hour:** Upon notification from OPS (BOC), the HQ Media Relations Manager will liaise with the relevant Regional A/Dir Comms in preparation of producing the required communications products (news release, media lines). The Significant Event Notification (SEN) issued by the BOC should help to inform the communications products.
4) **00:00-6 hours:** The relevant Regional A/Dir Communications will liaise with partners as the CBSA is prepping its products and will make efforts to coordinate the content and timing of the news release with provincial entities, as well as partners such as the investigating police partner.
5) **1-2 hours:** The relevant Regional A/Dir Comms will draft the required communications products based on input from OPS/relevant Region.
   a. The News Release will follow the template in accompanying Annex A of the approved *Public Communications Protocol – In-Custody Death*
6) **2-4 hours:** The relevant Regional A/Dir Comms forwards the draft communications products to the HQ Manager of Media Relations, who then processes the products for formal approvals through the established CAT 3 media relations process, in sequence as follows:
   a. RDG OPS
   b. DPASC
   c. DG Communications
   d. VP OPS/VP CAB
   e. EVPO / PO
7) The relevant Regional A/Dir Communications will make efforts to coordinate the content and timing of the news release with provincial entities, as well as partners such as the investigating police partner.
8) **4-4.5 hours:** Upon EVP / PO approval of the communications products, Media Relations (HQ) will provide the news release to Public Safety Communication for their awareness and to share with MINO for awareness. They will also share with PCO for awareness.
9) **4-5 hours:** Media Relations (HQ) will coordinate any translation or revision if required. During regular business hours, they will send to Revision (HQ). After hours, they will send to PSPC after-hours translation services which may take longer
10) **5-6 hours:** HQ Communications (Media Relations) will issue the news release (national distribution) on the newswire (this will take at least 30 minutes) and post online in the canada.ca newsroom. Media Relations (HQ) will then notify eCommunications (HQ) and they will post on social media. If incident occurs in Prairie or Atlantic, Regional Communications should also post on their regional twitter accounts.

11) **After 6 hours:** Media Relations (HQ) will include a link to the news release in the Nightly Media Wrap.
12) **After 6 hours:** Any corresponding incoming media queries will be treated based on the established CAT 3 media relations process.
13) Regional Communications will handle and issue the approved responses for all media queries.

Note: If at any point in the process there is media or social media interest, HQ Communications will respond with a holding media line until official communication products are issued.

After the Initial CBSA news release:

1) Communications will conduct an **8(2)(m)(i)** (of the *Privacy Act*) analysis in the context of a death in custody or serious injury, and will complete it within 72 hours of posting the news release, as follows:
    a. HQ Comms DG/ED/Dir PASC contacts the relevant Region's (OPS) A/Dir Communications to discuss details, as well as the Chief Privacy Officer to ensure continued engagement early in the process.
    b. The Regional A/Dir Communications drafts the 8(2)(m)(i) documents, including the interest vs injury matrix, briefing note and letter to Office of the Privacy Commissioner (OPC), with details provided by Regional Operations and Provincial counterpart (as applicable). The Issue Fact Sheet distributed by OPS (BOC) should help to inform the completion of the products.
    c. The VP CAB considers convening a meeting / teleconference of the HQ Incident Management Working Group (IMWG) (see Annex B), as applicable, comprised of relevant DGs to discuss considerations of the case, including but not limited to:
        i. Associate VP OPS Branch
        ii. Associate VP Programs Branch
        iii. Relevant RDG
        iv. Relevant Regional Director
        v. Director PSAC
        vi. Executive Director, Enforcement and Intelligence, Programs
        vii. DG, Security and Professional Standards, Comptrollership
        viii. DG Communications
        ix. Legal Services representative
        x. Chief Privacy Officer
        xi. Other VPs and DGs to be invited as the situation warrants
        xii. (Secretariat to be provided by CAB)

d. The DPSAC / DG Communications then completes the Matrix (based on input, consultation and supporting documentation from Operations Branch/Region). DG Comms submits the Matrix to the ATIP Division (HQ) along with its recommendation.
e. ATIP reviews the matrix and corresponding documents (briefing note, letter to the OPC) in concurrence with feedback from Legal Services Unit (HQ).
f. ATIP Division makes a recommendation to DG Corporate Secretariat.
g. DG Corporate Secretariat makes a recommendation to the VP CAB.
h. VP CAB approves or refuses.
i. If approved to release additional information, ATIP notifies the OPC.
j. Notification by VP CAB is provided for awareness to:
    i. EVPO / PO
    ii. PS
    iii. MINO
    iv. PCO
k. If refused, further information will not be released and the process ends.

After the (8)(2)(m)(i) assessment:

1) If release of additional information is approved based on the results of the 8(2)(m)(i) assessment, consider a second, updated news release, to provide more information (such as name of the deceased).
2) Any further public comment that is case-specific should be the responsibility of the external investigative body.

Updated: June 16, 2017

ANNEX A

Draft News Release

Visit the Branding Templates page for text spacing.

Death [or serious injury] of a detainee at [name of immigration holding centre, provincial facility or hospital].

Date
Ottawa, ON
Canada Border Services Agency

On [date], first responders were called to the [name of immigration holding centre or provincial facility or hospital] in [location] and a [X-year old male/female] detainee was [sent to a local hospital OR pronounced dead]. The [man/woman] passed away [in hospital] on [date], OR [The man/woman remains in hospital].

The [man/woman's] identity will not be released at this time.

[*If NoK have been notified:* Family of the deceased OR injured detainee have been notified.] As in all cases involving the death in CBSA custody, the police and the coroner have been notified. The CBSA will also be reviewing the circumstances of the incident - OR - The police are investigating the incident, and as in all cases involving serious injury or death of an individual in CBSA custody, the CBSA will be reviewing the circumstances of the incident.

The CBSA is not in a position to release further information while the investigation is ongoing.

Links

For more information about the law and policies about detention, please consult the CBSA website and Information for People Detained Under the *Immigration and Refugee Protection Act* (PDF, 448 KB).

Contacts

HQ Communications

Regional Media Relations

ANNEX B

DEATH or SERIOUS INJURY IN CBSA CUSTODY
Terms of Reference for the
HQ Incident Management Working Group

Mandate

The Vice-President, Corporate Affairs will convene a temporary HQ Incident Management Working Group within 60 days of a serious injury or death in CBSA custody to:

- Review the Due Diligence Report drafted by the relevant Region and the After Incident Report drafted by a committee of DG After Incident Review Working Group.
- Review on a regular basis the progress on the Management Response and Action Plan resulting from the Due Diligence Report and the National Management Action Plan resulting from the After Incident Report.
- Manage the preparation of briefing notes for the Minister and the President, to provide updates on the work of the Agency.
- Manage the review and preparation of materials for any inquest.
- Manage the review and preparation of communications products.
- Ensure that management of the work remains a priority for all involved at headquarters.

This temporary working group has only the decision making authority attributed to the positions of each of the members. Therefore, for some issues, the views of the President and/or Minister will need to be sought, subject to the views of the group and the Chair. The *Guidelines for Reporting and Investigating a Serious Incident in CBSA Custody and Control* should be used along with these Terms of Reference.

Membership

Chair: Vice-President, Corporate Affairs Branch
Members: Associate Vice-President, Operations Branch
Associate Vice-President, Programs Branch
Relevant Regional Director General
Relevant Regional Director
Director Public Affairs and Strategic Communications
Executive Director, Enforcement and Intelligence, Programs,
Director General, Security and Professional Standards, Comptrollership
Director General, Communications
Legal Services representative
Chief Privacy Officer

Other Vice-Presidents and Director Generals to be invited as the situation warrants
Secretariat: to be provided by Corporate Affairs Branch.

In order to ensure efficient operations, the working group uses a "no replacements" rule. Exceptions can be made by consulting with the Chair. Invitations to these meetings should not be forwarded or shared.

Working Group Operation (timelines are suggestions only)

Phase I – Immediately after the incident and until a few months before the inquest

The early meetings of the working group should be conducted by video-conference as much as possible, to foster a level of ease and trust among working group members to the extent possible. Primary objectives are to ensure that the required reports and work plans are prepared, that work proceeds at a steady pace, that communications to staff and media outlets are consistent, and that information is shared when needed.

All media enquiries related to the incident immediately become classified as "Category 3", and therefore require the review of Vice-presidents until the working group agrees that the issue can revert to regular assessment by Communications.

When a Coroner's Inquest is announced, participation of the CBSA in this process should be discussed. Points for consideration include the fact that a provincial Coroner does not have jurisdiction to compel a CBSA witness to testify before an Inquest nor to produce any documents or materials, and the fact that if or when the CBSA agrees to participate, that participation is on a voluntary basis and can be limited to the degree that CBSA finds appropriate, recognizing that issues may arise with the Coroner, stakeholders and the media. The provincial Coroner may also have the authority to seek an order from a superior court compelling CBSA's participation. Consultations with Legal Services are required.

If and when the CBSA decides to participate in an Inquest, an assigned lawyer from Legal Services at HQ will work with a Department of Justice litigator from the Regional Justice office, who will represent CBSA's interests at the Inquest and provide required client contact information to the coroner. The HQ Working Group will continue to liaise directly with the assigned lawyer from Legal Services at HQ.

Notwithstanding the above points, the CBSA intends, in general, to participate in inquests called by Coroner's offices, when appropriate, on a voluntary basis as these inquests provide an independent, public and transparent forum through which the incident can be reviewed.

Agendas and relevant documents should be prepared and distributed in advance of the meetings, and action items should be noted and reviewed at each meeting.

At this stage, the group can meet monthly or at the call of the Chair. Key messages must be identified, and lead OPIs and key points should be outlined. A sample template is provided at Annex C. A first draft of this document must be completed at least 60 days in advance of any

inquest. This document serves as an important reference document for many people, and therefore it is critical that this be updated and distributed rapidly as issues emerge.
The first briefing note to the Minister should be provided approximately 60 days in advance of any inquest, or on the direction of the President.

Phase II- three months before the inquest

At least 90 days before any inquest, the working group should begin meeting weekly in order to review documents to be shared with the Coroner's Service, and to ensure that communications materials such as an anticipatory News Release are reviewed and finalized. The Working Group may need to make more use of teleconference facilities. At some point in the preparations, the group will want to begin weekly reporting to the President.

The Minister should be provided with another briefing note not less than 15 days before the start of any inquest, to provide information about the Agency's progress on work plans, and to inform the Minister and his staff of the impending inquest.

Establish clear process for Question Period Notes: VP, CAB/DG Communications should take lead on crafting QP notes in the period leading up to and during the inquest, since all information and resources should have been gathered and maintained by CAB and Communications. Counsel assigned to the case must review any QP notes, and the fact that they have reviewed any QP notes needs to be transmitted to Public Safety.

Consideration should be given to sending an instructing client from HQ – perhaps a Director General from Operations, or the Director General of Recourse. Consideration should be given to the fact that some executives may be known to other witnesses and counsel, and therefore should *not* be sent to observe if there are no plans to have them testify.

The Department of Justice litigator and/or the assigned lawyer from Legal Services at HQ will report to the working group on the outcome of any pre-inquest conference convened by the coroner, as well as any pre-inquest interviews of CBSA witnesses by the coroner.

Phase III - Two days before and during the inquest

Plans need to be made for the arrival and departure of CBSA witnesses at the inquest. It should be expected that the assigned lawyer from Legal Services at HQ will attend the inquest in order to support the Department of Justice litigator and to liaise back with the working group at HQ

The proposed communications approach, main messages and proposed News Release for the end of the inquest should be developed, finalized and presented to the Minister's Office and PCO just before the start of the inquest. A sample is provided at Annex D.

Not less than two days before the start of any inquest, the working group should move to a meeting schedule of twice per day – in the morning and at night – to review the situation

reports that will be provided by the Region twice a day. The focus turns to care for CBSA employees called to testify, monitoring testimony, providing advice to Counsel and receiving feedback on a daily basis on developments from counsel, discussing strategic issues, and monitoring media. The VP CAB will debrief the President on developments at the end of each day, and will raise any urgent matters as needed.

Phase IV – Post-inquest

The Minister's Office should be briefed within two weeks of the conclusion of the inquest.

The working group can move to a meeting frequency of twice a month.

Work plans need to be developed and reviewed regularly to examine the recommendations coming from the inquest.

A briefing note should be provided to the Minister regarding the results of the inquest and the views of the Agency within three months of the conclusion of the inquest.

After the initial post-inquest memo has been provided to the Minister, the working group can move to a meeting frequency of once per month. The working group will continue to meet to review progress until the Agency has completed its work plan – which may require decisions by the President, the Minister, or even Cabinet - and a final memo can be provided to the Minister.

[A repository for all documents of business value needs to be identified and documents should be collected and archived.]

ANNEX C

Preparation for Inquest – Key Messages for development of Communications Lines and FAQs

Theme	"OPI"	Key Points
1.ie (Removals)		
2.		
3.		

ANNEX D

COMMUNICATIONS APPROACH
INQUEST

ISSUE:
On (date),…(describe event). The (insert relevant information) Coroner's Service has called an Inquest into the death that is scheduled to begin….

BACKGROUND:

CONSIDERATIONS:
-

COMMUNICATIONS OBJECTIVES:
-

AUDIENCES:
- Media
- Canadians

Partners

OGDs

Others

COMMUNICATIONS APPROACH:
A reactive approach is recommended for the period leading up to and during the Inquest. Communications will heavily monitor the public environment to detect possible issues and correct any false or misleading third-party statements…

Media will be directed …

A reactive approach is recommended immediately following the delivery of the verdict (identify next steps).

COMMUNICATIONS ACTIVITIES:

Activity	Target	Status	OPIs
Pre-Inquest			
During the Inquest			
Upon delivery of the verdict			
After review of the verdict			

KEY MESSAGES / HOLDING LINES

<u>For use by CBSA throughout the Inquest</u>

-

<u>For use by CBSA upon delivery of the Coroner's recommendations</u>

-

<u>Key messages for the statement</u>

-

Prepared by: CBSA Communications	**In consultation with:**	**Approved by:**

Public Communications Protocol — In-Custody Death

Effective October 25, 2016

The following protocol for public communications applies in the event of a death or serious injury in the custody of the Canada Border Services Agency (CBSA).

An "in-custody" death is defined as an incident where a person died while under the responsibility, physical care and/or control of the CBSA including, for example, under arrest or detention at a port of entry, in a CBSA immigration holding center or while detained in a provincial facility.

A "serious injury" is one that significantly alters the functioning of the individual (loss of sight, loss of limb or motor function), or which results in the death of the individual.

Please also refer to Operational Bulletins concerning procedures for death or serious injury in custody (

These Standard Operating Procedures (SOP) are in-line with partner agencies within the Public Safety portfolio (Royal Canadian Mounted Police and Correctional Services Canada), as well as, the CBSA operational policy on death in custody. Additionally, the CBSA will endeavour to coordinate its media approach with the applicable provincial facility. [1]

Application

This SOP applies to CBSA communications procedures when dealing with the death or serious injury of a detainee while in CBSA custody.

Objective

- To adopt a clear, consistent and transparent approach within the CBSA for public communications related to deaths and serious injuries in CBSA custody while respecting federal policies and legislation such as the *Privacy Act* and to be in line with Public Safety portfolio partners.
- To provide a common platform to communicate such occurrences in a transparent and consistent manner;
- To ensure that all CBSA communications align with the *CBSA Communication Policy and the Government of Canada (GoC) Communication Policy*; and comply with the *Privacy Act*, *Official Languages Act (OLA)*, CBSA policies, and other associated regulations.

[1] As each province has its own distinct rules and follows provincial legislation, vis-à-vis release of information, we work with these facilities to coordinate our communications — respecting each other's role and responsibilities in releasing information following a death in custody.

Process

Immediately following death or serious injury in custody (within 6 hours):

1. Within 6 hours of notification from authorities, the CBSA will issue a news release (NR) announcing the death or serious injury in custody, without releasing the name of the individual to the media.
    - Next of kin will be notified as quickly as possible, but the news release will not make reference to them if they have not been notified.
2. HQ will draft the communications products based on input from Operations/the Region, as required and securing approvals.
    - Operations/the Region must notify HQ/Communications **immediately** once they are aware of a death in custody as per operational protocol (
    - A death or serious injury in custody release is a "Category 3" release and requires Vice Presidents' and the President's approval (please refer to the media enquiries protocol media enquiry protocol).
3. The NR will follow the template in Annex A and will be issued on the newswire and be posted online in the Canada.ca newsroom and tweeted.
    - The release will briefly outline the events without breaching any security, privacy and/or investigative matters. It will include details such as date and location of the incident, which first responders attended, date that the individual passed away, and the agencies involved in the investigation. The NR should conclude that the CBSA is not in a position to release further information while the investigation is ongoing.
    - The NR will include general information on the event thus reinforcing the CBSA's commitment to transparency and accountability. The NR will **not** include the detainee's name; however it will include the individual's gender and age. This will permit the Agency to be as transparent as possible while respecting provisions of the *Privacy Act*.
4. Efforts will be made to coordinate the content and timing of the NR with provincial entities, but the NR will be provided for the President`s and Minister`s review regardless of the plans of partners. Partners, such as the investigating police partner, will be advised in advance of issuing the news release.
5. Depending on nature of incident, an internal message may also be released.

After the initial CBSA news release:

1. Conduct 8(2)(m)(i) (of the *Privacy Act*) analysis and complete it within 72 hours of posting the NR.
    a. Description of the process can be found at:

b. Supplementary information for this test is provided at:

c. The following explicitly identifies responsibilities for the section 8(2)(m)(i) analysis in the context of a death or serious injury in custody:
    i. DG Communications/Communications completes the Matrix with supporting documentation in consultation with Operations Branch/Regions and submits to ATIP Division;
    ii. ATIP reviews the matrix in concurrence with LSU;
    iii. ATIP makes a recommendation to the CPO (Director General, Corporate Secretariat);
    iv. CPO (DG, Corporate Secretariat) makes a recommendation to VP, CAB;
    v. Approval or refusal by VP, CAB;
    vi. ATIP notifies the OPC, if approved.

2. Consider a second, updated NR, to provide more information (such as name of the deceased), based on the results of the 8(2)(m)(i) assessment.
3. Any further public comment that is case-specific should be the responsibility of the external investigative body.

While the matter is under investigation by police / coroner:

1. The CBSA will adopt a responsive approach.
    - It is recommended media be referred to the NR posted online, and indicate that 'it would be inappropriate to comment further at this time as this is still under investigation.
    - Consideration may be given to responding in a general manner to questions, but need to avoid addressing case-specific questions while the investigation is ongoing.
    - Once the police / coroner's office have concluded their investigations, we may consider issuing another updated NR, posting an update to our website or updating our media lines accordingly.

If a Coroner's inquest is announced:

- During the period leading up to, and during, the inquest, the public environment will be monitored and messages may be adjusted accordingly. Corrective tweeting is also recommended as appropriate, with links to fact sheets, news releases, etc.

Following the release of the Coroner's report:

- Immediately following the release of the report, responsive holding lines should indicate that we are carefully reviewing the recommendations in the report.
- As soon as reasonably possible following the issuance of the coroner's report, a NR should be issued to acknowledge the completion of the inquest and outline the steps we have and will take to address concerns that may have arisen during the inquest.
- Until or unless otherwise directed, the Government of Canada does not "respond" in detail, or on a point-by-point basis, to recommendations from a provincial authority.

Annex A — Draft News Release

Visit the Branding Templates page for text spacing.

Death of a detainee at [name of holding centre]

Date
Ottawa, ON
Canada Border Services Agency

On [date], first responders were called to the [name of immigration holding centre] in [location] and a [X-year old male/female] detainee was [sent to a local hospital OR pronounced dead]. The [man/woman] passed away [in hospital] on [date].

The [man/woman's] identity will not be released at this time.

[*If NoK have been notified:* Family of the deceased have been notified.]

As in all cases involving the death in CBSA custody, the police and the coroner have been notified. The CBSA will also be reviewing the circumstances of the incident.

The CBSA is not in a position to release further information while the investigation is ongoing.

Links

For more information about the law and policies about detention, please consult the detentions fact sheet and Information for People Detained Under the *Immigration and Refugee Protection Act* (PDF, 448 KB).

Contacts

HQ Communications

Regional Media Relations

Public Communications Protocol — In-Custody Death

Effective October 25, 2016

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An "in-custody" death is defined as an incident where a person died while under the responsibility, physical care and/or control of the CBSA including, for example, under arrest or detention at a port of entry, in a CBSA immigration holding center or while detained in a provincial facility.

A "serious injury" is one that significantly alters the functioning of the individual (loss of sight, loss of limb or motor function), or which results in the death of the individual.

Please also refer to Operational Bulletins concerning procedures for death or serious injury in custody

These Standard Operating Procedures (SOP) are in-line with partner agencies within the Public Safety portfolio (Royal Canadian Mounted Police and Correctional Services Canada), as well as, the CBSA operational policy on death in custody. Additionally, the CBSA will endeavour to coordinate its media approach with the applicable provincial facility. [1]

Application

This SOP applies to CBSA communications procedures when dealing with the death or serious injury of a detainee while in CBSA custody.

Objective

- To adopt a clear, consistent and transparent approach within the CBSA for public communications related to deaths and serious injuries in CBSA custody while respecting federal policies and legislation such as the *Privacy Act* and to be in line with Public Safety portfolio partners.
- To provide a common platform to communicate such occurrences in a transparent and consistent manner;
- To ensure that all CBSA communications align with the *CBSA Communication Policy and the Government of Canada (GoC) Communication Policy*; and comply with the *Privacy Act*, *Official Languages Act (OLA)*, CBSA policies, and other associated regulations.

[1] As each province has its own distinct rules and follows provincial legislation, vis-à-vis release of information, we work with these facilities to coordinate our communications — respecting each other's role and responsibilities in releasing information following a death in custody.

Process

Immediately following death or serious injury in custody (within 6 hours):

1. Within 6 hours of notification from authorities, the CBSA will issue a news release (NR) announcing the death or serious injury in custody, without releasing the name of the individual to the media.
    - Next of kin will be notified as quickly as possible, but the news release will not make reference to them if they have not been notified.
2. HQ will draft the communications products based on input from Operations/the Region, as required and securing approvals.
    - Operations/the Region must notify HQ/Communications **immediately** once they are aware of a death in custody as per operational protocol
    - A death or serious injury in custody release is a "Category 3" release and requires Vice Presidents' and the President's approval (please refer to the media enquiries protocol media enquiry protocol).
3. The NR will follow the template in Annex A and will be issued on the newswire and be posted online in the Canada.ca newsroom and tweeted.
    - The release will briefly outline the events without breaching any security, privacy and/or investigative matters. It will include details such as date and location of the incident, which first responders attended, date that the individual passed away, and the agencies involved in the investigation. The NR should conclude that the CBSA is not in a position to release further information while the investigation is ongoing.
    - The NR will include general information on the event thus reinforcing the CBSA's commitment to transparency and accountability. The NR will **not** include the detainee's name; however it will include the individual's gender and age. This will permit the Agency to be as transparent as possible while respecting provisions of the *Privacy Act*.
4. Efforts will be made to coordinate the content and timing of the NR with provincial entities, but the NR will be provided for the President`s and Minister`s review regardless of the plans of partners. Partners, such as the investigating police partner, will be advised in advance of issuing the news release.
5. Depending on nature of incident, an internal message may also be released.

After the initial CBSA news release:

1. Conduct 8(2)(m)(i) (of the *Privacy Act*) analysis and complete it within 72 hours of posting the NR.
    a. Description of the process can be found at:

b. Supplementary information for this test is provided at:

c. The following explicitly identifies responsibilities for the section 8(2)(m)(i) analysis in the context of a death or serious injury in custody:
    i. DG Communications/Communications completes the Matrix with supporting documentation in consultation with Operations Branch/Regions and submits to ATIP Division;
    ii. ATIP reviews the matrix in concurrence with LSU;
    iii. ATIP makes a recommendation to the CPO (Director General, Corporate Secretariat);
    iv. CPO (DG, Corporate Secretariat) makes a recommendation to VP, CAB;
    v. Approval or refusal by VP, CAB;
    vi. ATIP notifies the OPC, if approved.

2. Consider a second, updated NR, to provide more information (such as name of the deceased), based on the results of the 8(2)(m)(i) assessment.
3. Any further public comment that is case-specific should be the responsibility of the external investigative body.

While the matter is under investigation by police / coroner:

1. The CBSA will adopt a responsive approach.
    - It is recommended media be referred to the NR posted online, and indicate that 'it would be inappropriate to comment further at this time as this is still under investigation.
    - Consideration may be given to responding in a general manner to questions, but need to avoid addressing case-specific questions while the investigation is ongoing.
    - Once the police / coroner's office have concluded their investigations, we may consider issuing another updated NR, posting an update to our website or updating our media lines accordingly.

If a Coroner's inquest is announced:

- During the period leading up to, and during, the inquest, the public environment will be monitored and messages may be adjusted accordingly. Corrective tweeting is also recommended as appropriate, with links to fact sheets, news releases, etc.

Following the release of the Coroner's report:

- Immediately following the release of the report, responsive holding lines should indicate that we are carefully reviewing the recommendations in the report.
- As soon as reasonably possible following the issuance of the coroner's report, a NR should be issued to acknowledge the completion of the inquest and outline the steps we have and will take to address concerns that may have arisen during the inquest.
- Until or unless otherwise directed, the Government of Canada does not "respond" in detail, or on a point-by-point basis, to recommendations from a provincial authority.

Annex A — Draft News Release

Visit the Branding Templates page for text spacing.

Death of a detainee at [name of holding centre]

Date
Ottawa, ON
Canada Border Services Agency

On [date], first responders were called to the [name of immigration holding centre] in [location] and a [X-year old male/female] detainee was [sent to a local hospital OR pronounced dead]. The [man/woman] passed away [in hospital] on [date].

The [man/woman's] identity will not be released at this time.

[*If NoK have been notified:* Family of the deceased have been notified.]

As in all cases involving the death in CBSA custody, the police and the coroner have been notified. The CBSA will also be reviewing the circumstances of the incident.

The CBSA is not in a position to release further information while the investigation is ongoing.

Links

For more information about the law and policies about detention, please consult the detentions fact sheet and Information for People Detained Under the *Immigration and Refugee Protection Act* (PDF, 448 KB).

Contacts

HQ Communications

Regional Media Relations

Protocole de communications publiques — Décès d'une personne en détention

En vigueur le ~~xx septembre~~25 octobre 2016

Le protocole suivant relatif aux communications publiques s'applique en cas de décès d'une personne détenue par l'Agence des services frontaliers du Canada (ASFC) ou de blessure grave subie par une telle personne.

Le « décès d'une personne en détention » est un incident où une personne décède pendant qu'elle se trouve sous la responsabilité, la garde ou le contrôle de l'ASFC, par exemple si elle est en état d'arrestation ou en détention dans un point d'entrée ou qu'elle est détenue dans un centre de surveillance de l'immigration de l'ASFC ou dans un établissement provincial.

Une « blessure grave » en est une qui altère considérablement le fonctionnement d'une personne (perte de la vue, perte d'un membre ou de la fonction motrice) ou qui entraîne le décès de la personne.

Veuillez également vous reporter aux bulletins opérationnels concernant les procédures à suivre en cas de décès ou de blessure grave en détention

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La présente procédure normale d'exploitation (PNE) correspond à celles des organismes partenaires du portefeuille de la Sécurité publique (Gendarmerie royale du Canada et Service correctionnel du Canada), ainsi qu'à la politique opérationnelle de l'ASFC relative aux décès en détention. En outre, l'ASFC tâchera de coordonner son approche médiatique avec l'établissement provincial concerné[1].

Application

La présente PNE s'applique aux communications de l'ASFC en lien avec le décès d'une personne détenue par l'ASFC ou une blessure grave subie par une telle personne.

Objectifs

[1] Chaque province possède ses propres règlements et adhère aux lois provinciales en ce qui concerne la divulgation d'information. Nous travaillerons donc avec ces établissements afin de coordonner nos communications, selon une approche qui tient compte de nos responsabilités et de nos rôles respectifs quant à la divulgation d'information à la suite du décès d'une personne en détention.

- Adopter une approche claire, uniforme et transparente à l'échelle de l'Agence en matière de communications publiques liées au décès d'une personne détenue par l'ASFC ou aux blessures graves subies par une telle personne, tout en respectant les politiques et les lois fédérales telles que la *Loi sur la protection des renseignements personnels*, et assurer la conformité avec les partenaires du portefeuille de la Sécurité publique.
- Fournir une tribune commune permettant de communiquer de telles situations de façon transparente et uniforme.
- Veiller à ce que toutes les communications de l'ASFC soient conformes à la *Politique de communication de l'ASFC* et à la *Politique de communication du gouvernement du Canada*, et à ce qu'elles respectent la *Loi sur la protection des renseignements personnels*, la *Loi sur les langues officielles*, les politiques de l'ASFC et les règlements connexes.

Processus

Immédiatement après le décès d'une personne en détention ou une blessure grave subie par une telle personne (dans les six heures) :

1. Dans les six heures suivant l'avis aux autorités, l'ASFC publiera un communiqué annonçant le décès ou la blessure grave en détention sans divulguer le nom de la personne aux médias.
    - Les proches en seront informés le plus rapidement possible; le communiqué ne fera pas allusion à eux s'ils n'en ont pas été informés.
2. L'Administration centrale (AC) rédigera les produits de communication en tenant compte des commentaires des Opérations ou de la région, et obtiendra les approbations nécessaires, au besoin.
    - Les Opérations ou la région doivent informer les Communications ou l'AC **aussitôt** qu'elles sont mises au fait du décès d'une personne en détention, conformément au protocole opérationnel

    - Les communiqués relatifs à un décès ou à une blessure grave en détention sont des communiqués de « catégorie 3 » et exigent l'approbation des vice-présidents et de la présidente (veuillez vous reporter au protocole concernant les demandes de renseignements des médias).
3. Le communiqué suivra le modèle à l'annexe A et sera publié sur le fil de presse, affiché dans la salle de rédaction du site Canada.ca et diffusé sur Twitter.
    - Le communiqué décrira brièvement la situation sans compromettre la sécurité, le droit à la vie privée ou toute enquête en cours. Les précisions fournies comprendront la date et le lieu de l'événement, les premiers intervenants sur les lieux, la date à laquelle la personne est décédée, et les organismes participant à l'enquête. Le communiqué devrait se terminer par une mention que l'ASFC ne peut diffuser aucun autre renseignement pendant la tenue de l'enquête.
    - Le communiqué comprendra des renseignements généraux sur l'événement, soulignant par le fait même l'engagement de l'ASFC envers la transparence et la responsabilisation. Le communiqué **ne** comprendra **pas** le nom de la personne détenue, seulement son sexe et son âge. Cette mesure permettra à l'Agence de

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faire preuve de toute la transparence possible tout en respectant les dispositions de la *Loi sur la protection des renseignements personnels*.

4. L'ASFC tâchera de coordonner le contenu et la date de diffusion du communiqué avec les entités provinciales, mais le communiqué sera présenté à la présidente et au ministre aux fins d'examen, peu importe les plans des partenaires. ~~Les partenaires~~Ces derniers, par exemple le service de police qui mène l'enquête, seront avisés à l'avance de la diffusion du communiqué~~, au cas où ils auraient des préoccupations~~.
5. Selon la nature de l'incident, un message interne pourrait également être diffusé.

Après la diffusion du premier communiqué de l'ASFC

1. Procéder à une analyse au titre du sous-alinéa 8(2)*m*)(i) de la *Loi sur la protection des renseignements personnels* et la compléter dans les 72 heures suivants la diffusion du communiqué.
    a. On trouve une description du processus au lien suivant~~Seek the consent~~ ;

    b. On trouve des renseignements supplémentaires sur ce test aux liens suivants ;

    c. La liste suivante précise les responsabilités associées aux analyses visées à l'alinéa 8(2)*m*)(i) en cas de décès d'une personne détenue ou de blessure grave subie par une telle personne ;
        i. Le directeur général des Communications (ou les Communications) remplit la matrice avec la documentation à l'appui, en consultation avec la Direction générale des opérations et les régions, et la transmet à la Division de l'AIPRP;
        ii. La Division de l'AIPRP révise la matrice, en parallèle avec l'Unité des services juridiques~~Monitor media coverage, and consider~~;
        iii. La Division de l'AIPRP fait une recommandation au chef de la protection des renseignements personnels (directeur général, Secrétariat général);
        iv. Le chef de la protection des renseignements personnels (directeur général, Secrétariat général) fait une recommandation au vice-président des Services intégrés;
        v. Le vice-président des Services intégrés approuve ou refuse la divulgation;

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vi. Si la divulgation est approuvée, la Division de l'AIPRP en avise le chef de la protection des renseignements personnels.

~~2. Obtenir le consentement des proches pour divulguer le nom de la personne décédée.~~

~~3.~~2. ~~Surveiller la couverture médiatique et e~~Envisager la publication d'un deuxième communiqué à jour pour fournir plus de renseignements (comme le nom de la personne décédée), en fonction des résultats obtenus aux évaluations visées à l'alinéa 8(2)*m*)i) ~~et du consentement des proches~~.

~~4.~~3. Tout commentaire public et spécifique devrait relever de l'organisme d'enquête externe.

Pendant l'enquête des corps policiers / du bureau du coroner :

- L'ASFC adoptera une approche réactive.
  - Il est recommandé de renvoyer les médias au communiqué en ligne et de préciser qu'il n'est pas indiqué de formuler d'autres commentaires pour l'instant vu que l'enquête est toujours en cours.
  - On pourrait envisager de répondre de façon générale aux questions, tout en évitant les questions spécifiques sur le dossier pendant la tenue de l'enquête.
  - Après que les corps policiers et le bureau du coroner auront terminé leur enquête, l'Agence pourrait envisager de diffuser un nouveau communiqué, de publier une mise à jour sur son site Web ou de mettre à jour les infocapsules en conséquence.

Si une enquête du coroner est annoncée :

- Pendant la période précédant la tenue de l'enquête, ainsi que l'enquête même, l'Agence surveillera l'environnement public et pourra ajuster ses messages en conséquence. Des gazouillis correctifs sont également recommandés, le cas échéant, pour fournir des liens vers des documents d'information, des communiqués, etc.

Après la diffusion du rapport d'enquête du coroner :

- Immédiatement après la diffusion du rapport, des infocapsules réactives devraient indiquer que l'Agence examine attentivement les recommandations du rapport.
- Le plus tôt possible après la diffusion du rapport d'enquête du coroner, l'Agence devrait publier un communiqué soulignant la fin de l'enquête et décrivant les mesures qui ont été ou qui seront prises en réponse aux préoccupations soulevées au cours de l'enquête.
- À moins d'indication contraire, le gouvernement du Canada ne doit pas « répondre » en détail, ou point par point, aux recommandations provenant d'une autorité provinciale.

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Annexe A — Ébauche de communiqué

Consultez le lien Modèles – Image de marque pour voir l'emplacement des paragraphes.

Décès d'une personne en détention au [nom du centre de surveillance]

Date
Ottawa (Ontario)
Agence des services frontaliers du Canada

Le [date], les premiers intervenants ont été appelés au [nom du centre de surveillance de l'immigration] à [endroit] et un/une détenu(e) âgé(e) de [âge] [a été transporté(e) à l'hôpital OU a été prononcé(e) mort(e)]. L'homme/La femme est décédé(e) [à l'hôpital] le [date].

Son identité ne sera pas divulguée pour l'instant.

[*Si les proches ont été informés :* Les proches du défunt/de la défunte ont été informés.]

Comme dans tous les cas de décès d'une personne détenue par l'ASFC, les services de police et le bureau du coroner ont été avisés. L'ASFC examinera également les circonstances de l'incident.

L'ASFC ne peut communiquer de renseignements supplémentaires pendant que l'enquête est en cours.

Liens

Pour en savoir plus sur la loi et les politiques qui encadrent la détention, veuillez consulter le ~~document d'information sur la détention~~ site web de l'ASFC et le document Renseignements à l'intention des personnes détenues en vertu de la *Loi sur l'immigration et la protection des réfugiés* (PDF, 448 Ko).

Personnes-ressources

Communications de l'AC

Équipe régionale des relations avec les médias

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President's Office time stamp / Timbre dateur du bureau du président

Canada Border Services Agency / Agence des services frontaliers du Canada

PROTECTED B

CBSA/ASFC-16-02916

ROUTING SLIP / BORDEREAU D'ACHEMINEMENT

Name and telephone number / Nom et numéro de téléphone	ACTION REQUIRED / MESURE REQUISE Initials and date / Initiales et date	Action	Information
Minister/Ministre The honourable Ralph Goodale L'honorable Ralph Goodale	JUL 07 2016	☐	☒
President/Présidente Linda Lizotte-MacPerson		☒	☐
Executive Vice-President/ Première vice-présidente Nada Semaan		☒	☐
Vice-President/ Vice-président(e) Caroline Xavier	JUL 06 2016	☒	☐
Associate Vice-President/ Vice-président(e) délégué Denis Vinette		☒	☐
Vice-President/ Vice-président(e) Jean-Stéphen Piché		☒	☐
Vice-President/ Vice-président(e) Caroline Weber	21 June 16	☒	☐
Legal Services/ Services juridiques Tom Saunders	30 JUNE 2016	☒	☐

Subject/Objet : **Conclusion of Coroner's inquest Into the 2014 death of a CBSA Detainee in Southern Ontario Region**

Action/Mesure : For approval / Pour approbation

Please find attached a briefing note to the Minister for information entitled "Conclusion of Coroner's inquest Into the 2014 death of a CBSA Detainee in Southern Ontario Region"

Canada Border Services Agency
Operations Branch, V.P.'s Office
JUL 05 2016
27550
Agence des services frontaliers du Canada
Direction générale des opérations, Bureau du V.P.

RECEIVED
JUL 04 2016
Vice-president Office/
Bureau du Vice-Président
Human Resources Branch/
Direction des ressources humaines

Canada

JUL 0 7 2016

Canada Border Services Agency | Agence des services frontaliers du Canada

PROTECTED B

For information

CONCLUSION OF CORONER'S INQUEST INTO THE 2014 DEATH OF A CANADA BORDER SERVICES AGENCY DETAINEE IN THE SOUTHERN ONTARIO REGION

For the Minister

PURPOSE

To inform you of the conclusion of a provincial coroner's inquest examining the circumstances surrounding the 2014 death of a Canada Border Services Agency (CBSA) detainee under the care and control of the Ontario Ministry of Community Safety and Correctional Services (MCSCS).

ISSUE

Following the September 2014 death of Mr. Dunn, a CBSA detainee, the Agency's Southern Ontario Region (SOR) and headquarters worked together to document and review the incident. While CBSA employees acted appropriately, some administrative issues were identified and addressed.

A provincial coroner's inquest into the death of Mr. Dunn was held May 2–5, 2016, in Welland, Ontario.

BACKGROUND

CBSA officers participated in the inquest as witnesses. Other witnesses included officers, the physician, a chaplain and nurse from the MCSCS, a detective and lead investigator from Niagara Regional Police, an inmate, and expert witnesses (a forensic pathologist and a forensic psychiatrist expert in the area of suicide risk assessment). Representatives from the United States (US) Consulate in Toronto and two journalists observed the proceedings.

In general, the witnesses spoke of their interaction with Mr. Dunn. They all described that there were no signs that he was in mental distress or was contemplating suicide.

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The jury's verdict was that Mr. Dunn had committed suicide, and the cause of death was anoxic brain injury due to hanging.

The jury made four recommendations.

To the MCSCS and the CBSA:

- Recommendation 1: That the CBSA and the MCSCS continue to ensure that appropriate medical information is consistently shared in a timely manner upon the admission of detainees into custody.

- Recommendation 2: That the CBSA and the MCSCS collaboratively continue to ensure that, when any new information comes to light or a change in risk occurs that is potentially relevant to the risk of suicide of a detainee, that information is promptly shared between the CBSA and the MCSCS in a consistent and clearly defined manner.

To the Immigration and Refugee Board (IRB):

- Recommendation 3: That the IRB have an independent and objective representative to meet with the detainee following the hearing to ensure his/her comprehension of the findings, if [the detainee is] not represented by counsel.

- Recommendation 4: That the IRB ensure that an independent representative complete a formal assessment of the stress level and suicide risk of the detainee and immediately communicate that assessment to the relevant caregivers.

The representatives of the US Consulate sent a letter to the Assistant Crown Attorney in the coroner's office expressing thanks for including them in the proceedings.

STATUS

As you will note, the recommendations to the CBSA are written in the form of continuing practices, thus recognizing that the CBSA and MCSCS had already established practices and procedures in these areas. The CBSA will continue to work to improve its policies and practices.

COMMUNICATIONS CONSIDERATIONS

An ongoing reactive approach to communications is recommended.

NEXT STEPS

The CBSA has a rigorous process in place for the review of serious injuries or death in custody, as well as a process for responding to inquests by provincial coroners, which was implemented for this inquest. No further actions are required.

Please note that I am available to discuss, or have CBSA officials brief your staff, at your convenience.

JUL 07 2016

Linda Lizotte-MacPherson
President

President's Office time stamp / Timbre dateur du bureau de la présidente

Canada Border Services Agency / Agence des services frontaliers du Canada

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CBSA/ASFC-16-04723

ROUTING SLIP / BORDEREAU D'ACHEMINEMENT

	ACTION REQUIRED/ MESURE REQUISE		
Name and telephone number/ Nom et numéro de téléphone	**Initials and date / Initiales et date**	**Action**	**Information**
President/Présidente Linda Lizotte-MacPherson	2 ~ OCT 25 2016	☐	☐
Executive Vice-President/ Première vice-présidente Nada Semaan		☐	☐
Vice-President/ Vice-président(e) Caroline Weber	CL Weber 24 Oct. 16	☐	☐
Director General/ Directeur(trice) général(e) Tel. /Tél. :			
Director/Directeur(trice) Tel. /Tél. :			

Subject/Objet : Communications Protocol for Responding to Death or Serious Injury in Custody
Action/Mesure : For approval / Pour approbation
BF/AR : 2016-10-28

As per the presentation at and decision by Executive Committee on June 29, 2016, and the subsequent meeting with you and others on September 23, the Communications Protocol for responding to death in custody has been revised, and the attached briefing note to the Minister has been prepared for his information.

Canada

For information

COMMUNICATIONS PROTOCOL FOR RESPONDING TO DEATH OR SERIOUS INJURY IN CUSTODY

For the Minister

PURPOSE

To inform you of the work done by the Canada Border Services Agency (CBSA) to address issues and improve the policy that was established in 2014 to notify the public when a death or serious injury occurs under CBSA detention. . (A "serious injury" is one that significantly alters the functioning of the individual (loss of sight, loss of limb or motor function), or which results in the death of the individual.)

ISSUE

CBSA has been accused in the media of a lack of transparency when providing information about deaths in CBSA custody. We have consulted with the Office of the Privacy Commissioner and colleagues in other departments and jurisdictions as part of a review to improve our communications protocol.

BACKGROUND

CBSA strives to be transparent, while at the same time obeying the laws and limits of what can be shared under the *Privacy Act*, the *Customs Act*, and the *Immigration and Refugee Protection Act*, among others. The tension between transparency and our requirements to protect privacy is evident in our efforts to communicate when there is a death of someone under a CBSA detention order.

Deaths of people under a CBSA detention order happen very infrequently (11 out of 98,722 detainees over 12 years (2004-2015)), but even one is cause for reflection and concern.

After a suicide attempt resulting in death at the British Columbia Immigration Holding Centre in 2013, the CBSA implemented a "Communications Protocol" in September 2014, to guide our efforts to be transparent about a death in custody, while respecting our privacy obligations.

The practices of the RCMP, Correctional Services of Canada (CSC), and a few provincial correctional facilities were reviewed to develop our protocol, recognizing that the legislative

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frameworks and functions of the CBSA are different from these other law enforcement partners and institutions. In particular, we would note that people who are arrested (and incarcerated) have generally been through a public proceeding in which they have been named. This is not true of many CBSA immigration detainees, who may be asylum seekers, and whose personal information needs to be protected even when the application for asylum is not successful.

Use of the protocol over the last two years has revealed areas for improvement. Notably, our practices regarding notification of next of kin, coordination with implicated partners (correctional facilities, police, etc.), and deliberations, due to increasing public pressure, about whether or not to release the name of the deceased, were not all explicitly addressed in the communications protocol, and therefore have caused delays in notifying the public.

ANALYSIS

There is considerable pressure from media to identify the deceased.

After careful consideration of all of the issues, review of the practices of other departments, and consultation with the Office of the Privacy Commissioner, we have decided to pursue a "two-step" approach to communicating with the public:

- Within six hours of notification from authorities that a death or serious injury under CBSA detention has occurred, a News Release will be issued by CBSA to report the date, where the incident occurred, age and gender of the individual, and whether the individual was sent to hospital or pronounced dead at the location where the incident occurred. Because of the risks to individuals posed by releasing personal information, and the delays in locating and contacting next of kin, CBSA's communications protocol requires that this first News Release does not identify the individual.

- Once the News Release has been posted, assessments of the situation will be made in keeping with the *Privacy Act*, and we will continue to monitor media, in order to determine whether it would be in the public interest to disclose the name of the deceased. If it is determined that release would be in the public interest, a second News Release will be posted to include this information.

STATUS

Our protocol has been revised to reflect the need to communicate accurately and rapidly, while protecting the personal information of the deceased. The revised protocol provides for the possibility of a second news release to identify the name of the deceased, as we continue to monitor the situation.

COMMUNICATIONS CONSIDERATIONS

Media will continue to place pressure on the CBSA to identify individuals who pass away while under CBSA detention hold. We have media lines to explain why protecting the privacy of individuals is so important.

NEXT STEPS

Officials are available to discuss this matter further with you or your office.

OCT 2 5 2016

Linda Lizotte-MacPherson
President

ATTACHMENTS

1. Public Communications Protocol – In-Custody Death

Namiesniowski, Tina

From: Dorion, Nicholas
Sent: June 6, 2018 09:34 PM
To: Namiesniowski, Tina
Cc: Blanchard, NathalieX; Eves, David; CBSA-ASFC-Media Relations; Melchers, Charles; Brunatti, Andrew; Medalla, Rocio; Namiesniowski, Tina; Slowey, Charles; Hill, PeterD(CBSA); Blanchard, NathalieX; Easton, Erika-Kirsten; Archipow, Nancy; Raider, Marc; Racicot, Kristine; Bolduc, Martin
Subject: EVP* URGENT - Media Query -BCIHC

Hi Mme Namiesniowski,

For your approval please. A response to a follow up from the Vancouver Sun on the BCIHC.

Approved by VP Programs, DG Comms, Dir CAB Comms branch, MMR and EIPD.

Apologies for the poor formatting. Currently working from my BB.

Merci!

Nicholas -

Time in: June 5, 2018 at 17:15 PST
Journalist:

Media: The Vancouver Sun

Telephone:

Deadline: June 6, 2018 at 17:00 PST

Topic: Follow-up, BCIHC

Question and answer:

Q: How does that differ from current operations involving contracted Guard Service?

A. CBSA Pacific Region operates and manages the facility remotely from their downtown office and provides presence at the site during the weekdays and conducts regular check-ins in the evenings and on weekends.

The CBSA will manage and operate the new facility with the assistance of the contracted Guard Service who will oversee daily operations of the centre.

CBSA will continue to be at the disposition of Immigration detainees at the new IHC.

The current immigration holding centre (IHC) at the Vancouver International Airport is a small facility that does not have adequate spaces for all levels of the CBSA to work on-site on a full-time basis.

As such, the CBSA operates and manages the facility remotely from the downtown office and provides a presence at the site during the weekdays and conducts regular check-ins in the evenings and on the weekends.

The CBSA regularly accesses the video monitoring footage inside the IHC at Vancouver International Airport to ensure the safety and security of detainees and to verify that contract commitments are being met.

The new IHC has been designed with office space to accommodate managers, several CBSA officers and administrative staff.

In early 2019 CBSA will permanently deploy these staff members to the new facility so that detainees have greater on-site access to the CBSA and to enhance the Agency's ability to provide oversight of the day to day operations.

Responses provided to reporter on June 5, 2018:

- The safety of detainees is a priority for the Agency.

- Any in-custody death is thoroughly investigated and corrective measures are taken.

- Following the direction of the coroner's jury recommendations into the Jiminez death, the Canada Border Services Agency (CBSA) made several improvements to the current immigration holding centre, including: improvements in staffing and oversight procedures, physical and mental health assessments, operational procedures and the development of training for contracted security guards and CBSA staff including suicide and self-injury prevention.

- Other recommendations will be addressed through features in the new facility scheduled to be opened in early 2019.

- Later this month, through the implementation of alternatives to detention, the CBSA will provide officers with an expanded set of tools and programs that will enable them to more effectively manage individual needs while ensuring public safety.

Q1. Is the CBSA building a new BCIHC? If so…

o Will it be staffed by CBSA employees?

o Will detainees have access to legal counsel, medical services, NGO's, spiritual & family visits?

o Will detainees have monitored internet access?

o Will telephones be readily available and capable of free local calls and the use of international calling cards?

o Will the BCIHC be above ground allowing natural light, ventilation and outside access?

- Will the facility have an onsite courtroom for immigration hearings?

- Will the new facility replace the existing facility at the Vancouver International Airport?

A1. On August 15, 2016, the Honourable Ralph Goodale, Minister of Public Safety and Emergency Preparedness, unveiled an agenda of change to transform Canada's immigration detention program. The National Immigration Detention Framework (https://www.cbsa-asfc.gc.ca/security-securite/detent/nidf-cndi-eng.html) includes an investment of $138 million to improve immigration detention infrastructure, provide better mental and medical health services at the CBSA Immigration Holding Centres (IHC), expand partnerships and alternatives to detention, and reduce the number of minors in detention across Canada.

As part of the Government of Canada's objective to improve its immigration detention system, the CBSA is constructing a new Immigration Holding Centre in Surrey, B.C, which is aligned to national standards for infrastructure. This new facility is designed specifically for immigration detention purposes and will replace the existing short-term IHC at the Vancouver International Airport. The new facility is scheduled to open by winter 2019 based on the current construction schedule.

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A2:

- Securiguard was awarded the security services contract with the CBSA in the Pacific Region in March 2018 and their in-service date was April 2018. The contract expires on July 31, 2020.

- Securiguard was awarded the contact based on the tender notice posted on the Government of Canada's Buy and Sell website. The specific tender can be found here:https://buyandsell.gc.ca/procurement-data/award-notice/PW-TOR-016-7394-001

- The CBSA will operate the new facility with CBSA Managers, Officers, Operational Support Staff as well as the contracted Guard Service.

- Immigration detainees will have full access to CBSA staff at the new IHC.

Q3. Are detained subjects given mental health assessments throughout their detention, and a Pre-Removal Risk Assessment?

A3. At the new IHC, detainees will have regular access to medical and mental health services in which they can access mental health assessments, throughout their time in Detention. If eligible, all persons facing

For more information on PRRA, please visit:https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/claim-protection-inside-canada/after-apply-next-steps/refusal-options/pre-removal-risk-assessment.html.

Q4. Are Securiguard staff given mandatory training that involves suicide prevention, courses relating to the mental health of others, the handling of detainees in a respectful manner, and diversity training?

A4. Securigard staff are provided mandatory training on suicide prevention, mental health, diversity training and respect in the workplace.

Q5. Is CBSA currently accessing the video monitoring system inside YVR's Immigration Detention Centre at random times to ensure the staffing levels and contract commitments are being made?

A5. The CBSA confirms the Agency regularly accesses the video monitoring footage inside the IHC at the Vancouver International Airport to ensure the safety and security of detainees and to verify contract commitments are being met.

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A6. The average number of detained persons in the Pacific Region on any given day is 28 (From January 1, 2018 to March 31, 2018). The average number of detention days is 6.6 days. It is important to note that detention is used as a last resort after a careful review of all the factors leading to their detention and any available alternatives to detention. Further to this, the CBSA publishes national statistics on detention, which can be found at https://www.cbsa-asfc.gc.ca/security-securite/detent/qstat-2017-2018-eng.html.

Sent from my BlackBerry 10 smartphone on the Rogers network.
Original Message
From: Bolduc, Martin
Sent: Wednesday, June 6, 2018 8:51 PM
To: Dorion, Nicholas; Hill, PeterD(CBSA); Slowey, Charles
Cc: Blanchard, NathalieX; Eves, David; CBSA-ASFC-Media Relations; Melchers, Charles; Brunatti, Andrew; Medalla, Rocio; Namiesniowski, Tina
Subject: Re: VP Programs * URGENT - Media Query -BCIHC

I would prefer we say that contacted guards services will still be used to oversee daily Operations with additional CBSA presence.....

The way the response is framed leads the reader that we have NO Présence on site

MB
Envoyé de mon smartphone BlackBerry 10 sur le réseau Rogers.
De: Dorion, Nicholas
Envoyé: mercredi 6 juin 2018 20:44
À: Hill, PeterD(CBSA); Slowey, Charles; Bolduc, Martin
Cc: Blanchard, NathalieX; Eves, David; CBSA-ASFC-Media Relations; Melchers, Charles; Brunatti,

Objet: Re: VP Programs * URGENT - Media Query -BCIHC

Apologies. If we could get approval by 21:00 at the latest please.

Sent from my BlackBerry 10 smartphone on the Rogers network.
From: Dorion, Nicholas
Sent: Wednesday, June 6, 2018 8:12 PM
To: Hill, PeterD(CBSA); Slowey, Charles; Bolduc, Martin
Cc: Blanchard, NathalieX; Eves, David; Racicot, Kristine; CBSA-ASFC-Media Relations; Archipow, Nancy; Easton, Erika-Kirsten; Raider, Marc; Melchers, Charles; Brunatti, Andrew; Medalla, Rocio
Subject: VP Programs * URGENT - Media Query -BCIHC

Hi,

For your approval please. A response to a follow up from the Vancouver Sun on the BCIHC.

Approved by DG Comms, Dir CAB Comms branch, MMR and EIPD.

Apologies for the poor formatting. Currently working from my BB.

Merci!

Nicholas -

Time in: June 5, 2018 at 17:15 PST
Journalist:

Media: The Vancouver Sun

Telephone:

Deadline: June 6, 2018 at 17:00 PST

Topic: Follow-up, BCIHC

Question and answer:

Q: How does that differ from current operations involving contracted Guard Service?

A. CBSA Pacific Region operates and manages the facility remotely from their downtown office and provides presence at the site during the weekdays and conducts regular check-ins in the evenings and on weekends.

The CBSA will manage and operate the new facility with the assistance of the contracted Guard Service who will oversee daily operations of the centre.

CBSA will continue to be at the disposition of Immigration detainees at the new IHC.

The current immigration holding centre (IHC) at the Vancouver International Airport is a small facility that does not have adequate spaces for all levels of the CBSA to work on-site on a full-time basis.

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The new IHC has been designed with office space to accommodate managers, several CBSA officers and administrative staff.

In early 2019 CBSA will permanently deploy these staff members to the new facility so that detainees have greater on-site access to the CBSA and to enhance the Agency's ability to provide oversight of the day to day operations.

Responses provided to reporter on June 5, 2018:

· The safety of detainees is a priority for the Agency.

· Any in-custody death is thoroughly investigated and corrective measures are taken.

· Following the direction of the coroner's jury recommendations into the Jiminez death, the Canada Border Services Agency (CBSA) made several improvements to the current immigration holding centre, including: improvements in staffing and oversight procedures, physical and mental health assessments, operational procedures and the development of training for contracted security guards and CBSA staff including suicide and self-injury prevention.

· Other recommendations will be addressed through features in the new facility scheduled to be opened in early 2019.

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o Will the BCIHC be above ground allowing natural light, ventilation and outside access?

o Will detainees be allowed to wear civilian clothing.

- Will the facility have an onsite courtroom for immigration hearings?

- Will the new facility replace the existing facility at the Vancouver International Airport?

A1. On August 15, 2016, the Honourable Ralph Goodale, Minister of Public Safety and Emergency Preparedness, unveiled an agenda of change to transform Canada's immigration detention program. The National Immigration Detention Framework (https://www.cbsa-asfc.gc.ca/security-securite/detent/nidf-cndi-eng.html) includes an investment of $138 million to improve immigration detention infrastructure, provide better mental and medical health services at the CBSA Immigration Holding Centres (IHC), expand partnerships and alternatives to detention, and reduce the number of minors in detention across Canada.

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Q3. Are detained subjects given mental health assessments throughout their detention, and a Pre-Removal Risk Assessment?

A3. At the new IHC, detainees will have regular access to medical and mental health services in which they can access mental health assessments, throughout their time in Detention. If eligible, all persons facing removal from Canada can apply for a Pre-Removal Risk Assessment (PRRA), including those in detention.

citizenship/services/refugees/claim-protection-inside-canada/after-apply-next-steps/refusal-options/pre-removal-risk-assessment.html.

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A4. Securigard staff are provided mandatory training on suicide prevention, mental health, diversity training and respect in the workplace.

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A5. The CBSA confirms the Agency regularly accesses the video monitoring footage inside the IHC at the Vancouver International Airport to ensure the safety and security of detainees and to verify contract commitments are being met.

Q6. At any given time, what is the average number of persons detained in Vancouver under the Immigration and Refugee Protection Act? What is their average length of stay?

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Sent from my BlackBerry 10 smartphone on the Rogers network.
From: CBSA-ASFC-Media Relations <Media.Relations@cbsa-asfc.gc.ca>
Sent: Wednesday, June 6, 2018 6:42 PM
To: Giolti, Patrizia; Dorion, Nicholas; Campbell, Barre Grant; Marriner, Kathleen; Robertson, Jayden
Subject: FW: URGENT - For review and approval – Cat 3 – Vancouver IHC (supplementary)

From: Archipow, Nancy
Sent: June-06-18 06:42:55 PM (UTC-05:00) Eastern Time (US & Canada)
To: Giolti, Patrizia; Easton, Erika-Kirsten
Cc: CBSA-ASFC-Media Relations; Mauviel, Anna; Racicot, Kristine
Subject: Re: URGENT - For review and approval – Cat 3 – Vancouver IHC (supplementary)

Pls qualify what kind of presence we have now. Do we ever have CBSA presence at the facility?

Are the highlighted bullets from the previous Response?

Also, there's a small typo in the question and the last sentence.

Sent from my BlackBerry 10 smartphone on the Rogers network.
From: Giolti, Patrizia
Sent: Wednesday, June 6, 2018 6:18 PM
To: Archipow, Nancy; Easton, Erika-Kirsten
Cc: CBSA-ASFC-Media Relations; Mauviel, Anna; Racicot, Kristine
Subject: URGENT - For review and approval – Cat 3 – Vancouver IHC (supplementary)

Hi Nancy and Erika, to expedite sending to you both. Please advise if any issues.
RDG and DG EIPD approved

Time in: June 5, 2018 at 17:15 PST
Journalist:
Media: The Vancouver Sun
Telephone:
Deadline: June 6, 2018 at 17:00 PST
Topic: Follow-up, BCIHC
Question and answer:

Q: How does that differ from current oerations involving contracted Guard Service?

- The CBSA will operate the new facility with CBSA Managers, Officers, Operational Support Staff as well as the contracted Guard Service.
- Immigration detainees will have full access to CBSA staff at the new IHC.

Response: The current immigration holding centre (IHC) at the Vancouver International Airport is a small facility that does not have adequate spaces for all levels of the CBSA to work on-site on a full-time basis.

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A4. Securigard staff are provided mandatory training on suicide prevention, mental health, diversity training and respect in the workplace.

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Namiesniowski, Tina

From: Dorion, Nicholas
Sent: June 6, 2018 10:42 PM
To: Namiesniowski, Tina
Cc: Melchers, Charles; Brunatti, Andrew
Subject: Re: EVP* URGENT - Media Query -BCIHC

OK. No worries.

We'll revise accordingly and resend tomorrow morning.

Have a good evening.

Nicholas

Sent from my BlackBerry 10 smartphone on the Rogers network.

From: Namiesniowski, Tina
Sent: Wednesday, June 6, 2018 10:12 PM
To: Dorion, Nicholas
Cc: Melchers, Charles; Brunatti, Andrew
Subject: Re: EVP* URGENT - Media Query -BCIHC

Just saw this. As indicated before, if you need urgent approval please feel free to call me at home... Find answer confusing.

Do we use guards at the IHC in the Vancouver airport? Find answer unclear. Also unclear as to their role at the new Surrey facility. Have tried to clarify - this needs to be verified. If answer is correct please assume approval.

The current immigration holding centre (IHC) at the Vancouver International Airport is a small facility that does not have adequate spaces for all levels of the CBSA to work on-site on a full-time basis. The cbsa uses contracted Guard services at this facility in support of cbsa operations.

The CBSA operates and manages the facility from its downtown Vancouver?? office and provides a presence at the site during the weekdays. CBSA conducts regular check-ins in the evenings and on the weekends. This includes accessing the video monitoring footage inside the IHC at Vancouver International Airport to ensure the safety and security of detainees and to verify that contract commitments are being met.

The new IHC has been designed with office space to accommodate managers, several CBSA officers and administrative staff.

In early 2019 CBSA will permanently deploy staff members to the new facility located in Surrey so that detainees have greater on-site access to the CBSA and to enhance the Agency's ability to provide oversight of the day to day operations that will continue to be supported through contracted Guard services.

Original Message

From: Dorion, Nicholas
Sent: Wednesday, June 6, 2018 9:51 PM
To: Namiesniowski, Tina
Cc: Melchers, Charles; Brunatti, Andrew
Subject: Re: EVP* URGENT - Media Query -BCIHC

Hi,

Apologies, forgot to mention that,as this is a PAC call, there was a 20:00ET deadline. Even though we missed the reporter's deadline, we feel it would be beneficial for the Agency to provide a response this evening as it is still 19:00 in BC and the reporter has indicated that he will be filing his story tomorrow.

Seeking your approval by 10:00-10:15 if possible.

Merci,

Nicholas -

Sent from my BlackBerry 10 smartphone on the Rogers network.

From: Dorion, Nicholas
Sent: Wednesday, June 6, 2018 9:33 PM
To: Namiesniowski, Tina
Cc: Blanchard, NathalieX; Eves, David; CBSA-ASFC-Media Relations; Melchers, Charles; Brunatti, Andrew; Medalla, Rocio; Namiesniowski, Tina; Slowey, Charles; Hill, PeterD(CBSA); Blanchard, NathalieX; Easton, Erika-Kirsten; Archipow, Nancy; Raider, Marc; Racicot, Kristine; Bolduc, Martin
Subject: EVP* URGENT - Media Query -BCIHC

Hi Mme Namiesniowski,

For your approval please. A response to a follow up from the Vancouver Sun on the BCIHC.

Approved by VP Programs, DG Comms, Dir CAB Comms branch, MMR and EIPD.

Apologies for the poor formatting. Currently working from my BB.

Merci!

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Time in: June 5, 2018 at 17:15 PST
Journalist:

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A5. The CBSA confirms the Agency regularly accesses the video monitoring footage inside the IHC at the Vancouver International Airport to ensure the safety and security of detainees and to verify contract commitments are being met.

Q6. At any given time, what is the average number of persons detained in Vancouver under the Immigration and Refugee Protection Act? What is their average length of stay?

A6. The average number of detained persons in the Pacific Region on any given day is 28 (From January 1, 2018 to March 31, 2018). The average number of detention days is 6.6 days. It is important to note that detention is used as a last resort after a careful review of all the factors leading to their detention and any available alternatives to detention. Further to this, the CBSA publishes national statistics on detention, which can be found at https://www.cbsa-asfc.gc.ca/security-securite/detent/qstat-2017-2018-eng.html.

Sent from my BlackBerry 10 smartphone on the Rogers network.
Original Message

Sent: Wednesday, June 6, 2018 8:51 PM
To: Dorion, Nicholas; Hill, PeterD(CBSA); Slowey, Charles
Cc: Blanchard, NathalieX; Eves, David; CBSA-ASFC-Media Relations; Melchers, Charles; Brunatti, Andrew; Medalla, Rocio; Namiesniowski, Tina
Subject: Re: VP Programs * URGENT - Media Query -BCIHC

I would prefer we say that contacted guards services will still be used to oversee daily Operations with additional CBSA presence.....

The way the response is framed leads the reader that we have NO Présence on site

MB
Envoyé de mon smartphone BlackBerry 10 sur le réseau Rogers.
De: Dorion, Nicholas
Envoyé: mercredi 6 juin 2018 20:44
À: Hill, PeterD(CBSA); Slowey, Charles; Bolduc, Martin
Cc: Blanchard, NathalieX; Eves, David; CBSA-ASFC-Media Relations; Melchers, Charles; Brunatti, Andrew; Medalla, Rocio; Namiesniowski, Tina
Objet: Re: VP Programs * URGENT - Media Query -BCIHC

Apologies. If we could get approval by 21:00 at the latest please.

Sent from my BlackBerry 10 smartphone on the Rogers network.
From: Dorion, Nicholas
Sent: Wednesday, June 6, 2018 8:12 PM
To: Hill, PeterD(CBSA); Slowey, Charles; Bolduc, Martin
Cc: Blanchard, NathalieX; Eves, David; Racicot, Kristine; CBSA-ASFC-Media Relations; Archipow, Nancy; Easton, Erika-Kirsten; Raider, Marc; Melchers, Charles; Brunatti, Andrew; Medalla, Rocio
Subject: VP Programs * URGENT - Media Query -BCIHC

Hi,

For your approval please. A response to a follow up from the Vancouver Sun on the BCIHC.

Approved by DG Comms, Dir CAB Comms branch, MMR and EIPD.

Apologies for the poor formatting. Currently working from my BB.

Merci!

Nicholas -

Time in: June 5, 2018 at 17:15 PST
Journalist:

Media: The Vancouver Sun

Telephone:

Deadline: June 6, 2018 at 17:00 PST

Topic: Follow-up, BCIHC

Question and answer:

Q: How does that differ from current operations involving contracted Guard Service?

A. CBSA Pacific Region operates and manages the facility remotely from their downtown office and provides presence at the site during the weekdays and conducts regular check-ins in the evenings and on weekends.

The CBSA will manage and operate the new facility with the assistance of the contracted Guard Service who will oversee daily operations of the centre.

CBSA will continue to be at the disposition of Immigration detainees at the new IHC.

The current immigration holding centre (IHC) at the Vancouver International Airport is a small facility that does not have adequate spaces for all levels of the CBSA to work on-site on a full-time basis.

As such, the CBSA operates and manages the facility remotely from the downtown office and provides a presence at the site during the weekdays and conducts regular check-ins in the evenings and on the weekends.

The CBSA regularly accesses the video monitoring footage inside the IHC at Vancouver International Airport to ensure the safety and security of detainees and to verify that contract commitments are being met.

The new IHC has been designed with office space to accommodate managers, several CBSA officers and administrative staff.

In early 2019 CBSA will permanently deploy these staff members to the new facility so that detainees have greater on-site access to the CBSA and to enhance the Agency's ability to provide oversight of the day to day operations.

Responses provided to reporter on June 5, 2018:

- The safety of detainees is a priority for the Agency.

- Any in-custody death is thoroughly investigated and corrective measures are taken.

- Following the direction of the coroner's jury recommendations into the Jiminez death, the Canada Border Services Agency (CBSA) made several improvements to the current immigration holding centre, including: improvements in staffing and oversight procedures, physical and mental health assessments, operational procedures and the development of training for contracted security guards and CBSA staff including suicide and self-injury prevention.

- Other recommendations will be addressed through features in the new facility scheduled to be opened in early 2019.

- Later this month, through the implementation of alternatives to detention, the CBSA will provide officers with an expanded set of tools and programs that will enable them to more effectively manage individual needs while ensuring public safety.

Q1. Is the CBSA building a new BCIHC? If so…

o Will it be staffed by CBSA employees?

o Will detainees have access to legal counsel, medical services, NGO's, spiritual & family visits?

o Will detainees have monitored internet access?

o Will telephones be readily available and capable of free local calls and the use of international calling cards?

o Will the BCIHC be above ground allowing natural light, ventilation and outside access?

o Will detainees be allowed to wear civilian clothing.

o Will the facility have an onsite courtroom for immigration hearings?

o Will the new facility replace the existing facility at the Vancouver International Airport?

A1. On August 15, 2016, the Honourable Ralph Goodale, Minister of Public Safety and Emergency Preparedness, unveiled an agenda of change to transform Canada's immigration detention program. The National Immigration Detention Framework (https://www.cbsa-asfc.gc.ca/security-securite/detent/nidf-cndi-eng.html) includes an investment of $138 million to improve immigration detention infrastructure, provide better mental and medical health services at the CBSA Immigration Holding Centres (IHC), expand partnerships and alternatives to detention, and reduce the number of minors in detention across Canada.

As part of the Government of Canada's objective to improve its immigration detention system, the CBSA is constructing a new Immigration Holding Centre in Surrey, B.C, which is aligned to national standards for infrastructure. This new facility is designed specifically for immigration detention purposes and will replace the existing short-term IHC at the Vancouver International Airport. The new facility is scheduled to open by winter 2019 based on the current construction schedule.

The new British Columbia IHC in Surrey will be located at 13130 76 Avenue Surrey, B.C. The site is a former RCMP building that is currently being retrofitted on the interior to become the future IHC.

Immigration detainees being held at the new IHC will have access to: natural light within the facility, outdoor recreational activities; on-site medical and mental health services; on-site immigration hearing rooms; non-government organizations, legal representatives, spiritual or religious services, in-person visits; access to telephones capable of free local calls and use of international calling cards. As has always been the case in all IHCs across Canada, detainees will continue to be allowed to wear civilian clothing.

Q2: Can I please get additional details on the contract with Securiguard? How long will they be employed? And will they be used at the new immigration holding centre?

A2:

· Securiguard was awarded the security services contract with the CBSA in the Pacific Region in March 2018 and their in-service date was April 2018. The contract expires on July 31, 2020.

Canada's Buy and Sell website. The specific tender can be found here:https://buyandsell.gc.ca/procurement-data/award-notice/PW-TOR-016-7394-001

- The CBSA will operate the new facility with CBSA Managers, Officers, Operational Support Staff as well as the contracted Guard Service.

- Immigration detainees will have full access to CBSA staff at the new IHC.

Q3. Are detained subjects given mental health assessments throughout their detention, and a Pre-Removal Risk Assessment?

A3. At the new IHC, detainees will have regular access to medical and mental health services in which they can access mental health assessments, throughout their time in Detention. If eligible, all persons facing removal from Canada can apply for a Pre-Removal Risk Assessment (PRRA), including those in detention. For more information on PRRA, please visit:https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/claim-protection-inside-canada/after-apply-next-steps/refusal-options/pre-removal-risk-assessment.html.

Q4. Are Securiguard staff given mandatory training that involves suicide prevention, courses relating to the mental health of others, the handling of detainees in a respectful manner, and diversity training?

A4. Securigard staff are provided mandatory training on suicide prevention, mental health, diversity training and respect in the workplace.

Q5. Is CBSA currently accessing the video monitoring system inside YVR's Immigration Detention Centre at random times to ensure the staffing levels and contract commitments are being made?

A5. The CBSA confirms the Agency regularly accesses the video monitoring footage inside the IHC at the Vancouver International Airport to ensure the safety and security of detainees and to verify contract commitments are being met.

Q6. At any given time, what is the average number of persons detained in Vancouver under the Immigration and Refugee Protection Act? What is their average length of stay?

A6. The average number of detained persons in the Pacific Region on any given day is 28 (From January 1, 2018 to March 31, 2018). The average number of detention days is 6.6 days. It is important to note that detention is used as a last resort after a careful review of all the factors leading to their detention and any available alternatives to detention. Further to this, the CBSA publishes national statistics on detention, which can be found at https://www.cbsa-asfc.gc.ca/security-securite/detent/qstat-2017-2018-eng.html.

Sent from my BlackBerry 10 smartphone on the Rogers network.
From: CBSA-ASFC-Media Relations <Media.Relations@cbsa-asfc.gc.ca>

To: Giolti, Patrizia; Dorion, Nicholas; Campbell, Barre Grant; Marriner, Kathleen; Robertson, Jayden
Subject: FW: URGENT - For review and approval – Cat 3 – Vancouver IHC (supplementary)

From: Archipow, Nancy
Sent: June-06-18 06:42:55 PM (UTC-05:00) Eastern Time (US & Canada)
To: Giolti, Patrizia; Easton, Erika-Kirsten
Cc: CBSA-ASFC-Media Relations; Mauviel, Anna; Racicot, Kristine
Subject: Re: URGENT - For review and approval – Cat 3 – Vancouver IHC (supplementary)

Pls qualify what kind of presence we have now. Do we ever have CBSA presence at the facility?

Are the highlighted bullets from the previous Response?

Also, there's a small typo in the question and the last sentence.

Sent from my BlackBerry 10 smartphone on the Rogers network.
From: Giolti, Patrizia
Sent: Wednesday, June 6, 2018 6:18 PM
To: Archipow, Nancy; Easton, Erika-Kirsten
Cc: CBSA-ASFC-Media Relations; Mauviel, Anna; Racicot, Kristine
Subject: URGENT - For review and approval – Cat 3 – Vancouver IHC (supplementary)

Hi Nancy and Erika, to expedite sending to you both. Please advise if any issues.
RDG and DG EIPD approved

Time in: June 5, 2018 at 17:15 PST
Journalist:
Media: The Vancouver Sun
Telephone:
Deadline: June 6, 2018 at 17:00 PST
Topic: Follow-up, BCIHC
Question and answer:

Q: How does that differ from current oerations involving contracted Guard Service?

- The CBSA will operate the new facility with CBSA Managers, Officers, Operational Support Staff as well as the contracted Guard Service.
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Response: The current immigration holding centre (IHC) at the Vancouver International Airport is a small facility that does not have adequate spaces for all levels of the CBSA to work on-site on a full-time basis.

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Responses provided to reporter on June 5, 2018:

- The safety of detainees is a priority for the Agency.
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Public Communications Protocol — In-Custody Death or Serious Injury

Effective May 1, 2018

The following protocol for public communications applies in the event of a death or serious injury in the custody of the Canada Border Services Agency (CBSA).

An "in-custody" death is defined as an incident where a person died while under the responsibility, physical care and/or control of the CBSA including, for example, under arrest or detention at a port of entry, in a CBSA immigration holding centre or while detained in a provincial facility.

A "serious injury" is one that significantly alters the functioning of the individual (loss of sight, loss of limb or motor function), or which results in the death of the individual.

Please also refer to Operational Bulletins concerning procedures for death or serious injury in custody

These Standard Operating Procedures (SOP) are in-line with partner agencies within the Public Safety portfolio (Correctional Service Canada and Royal Canadian Mounted Police), as well as the CBSA operational policy on death in custody or serious injury. Additionally, the CBSA will endeavour to coordinate its media approach with the applicable provincial facility. [1]

Application

This SOP applies to CBSA communications procedures when dealing with the death or serious injury of a detainee while in CBSA custody.

Objective

- To adopt a clear, consistent and transparent approach within the CBSA for public communications related to deaths and serious injuries in CBSA custody, while respecting federal policies and legislation such as the *Privacy Act* and to be in line with Public Safety portfolio partners.
- To provide a common platform to communicate such occurrences in a transparent and consistent manner;

[1] As each province has its own distinct rules and follows provincial legislation, vis-à-vis release of information, we work with these facilities to coordinate our communications — respecting each other's role and responsibilities in releasing information following a death in custody or serious injury.

- To ensure that all CBSA communications align with the *CBSA Communications Policy and the Government of Canada (GoC) Communications Policy*; and comply with the *Privacy Act*, *Official Languages Act (OLA)*, CBSA policies, and other associated regulations.

Process

Immediately following death or serious injury in custody:

1. Conduct a public interest disclosure versus injury to privacy assessment – 8(2)(m)(i) of the *Privacy Act* – and complete it within 72 hours of notification by the authorities. Description of the process can be found at:

    o

    o

Issue one news release (NR) within 72 hours of notification from authorities – and after all efforts have been made to complete the notification of next of kin. This will demonstrate care and compassion by the CBSA following a death in custody or serious injury, while promoting a culture of transparency and accountability. Notification of next of kin will take place as soon as possible to expedite the process in a timely, responsible manner.

2. The NR will follow the template in Annex A and will be issued on the newswire and be posted online in the Canada.ca newsroom and tweeted.
    - The NR will include the detainee's name (if deemed to be in the public interest), gender and age. This will permit the Agency to be as transparent as possible while respecting provisions of the *Privacy Act*.
    - The NR will include general information on the event thus reinforcing the CBSA's commitment to transparency and accountability, including a brief outline of events without breaching any security, privacy and/or investigative matters. It will include details such as date and location of the incident, which first responders attended, date that the individual passed away, and the agencies involved in the investigation.
    - The NR should conclude that the CBSA is not in a position to release further information while the investigation is ongoing.

3. HQ will draft the communications products based on input from Operations/the Region, as required and securing approvals.
    - Operations/the Region must notify HQ/Communications **immediately** once they are aware of a death in custody as per operational protocol

    - A death or serious injury in custody release is a "Category 3" release and requires Vice-Presidents', Executive Vice-President's and President's approval (please refer to the media enquiries protocol media enquiry protocol).

4. Efforts will be made to coordinate the content and timing of the NR with provincial entities, but the NR will be provided for the Executive Vice-President's, President's and Minister's review regardless of the plans of partners. Partners, such as the investigating police partner, will be advised in advance of issuing the news release.
5. Depending on nature of incident, an internal message may also be released.

After the CBSA news release has been issued:

1. Communications may publicly release additional information as appropriate through the approved process, to reinforce the CBSA's commitment to transparency and accountability, without breaching any security, privacy and/or investigative matters.

Supplementary information for the 8(2)(m)(i) analysis is provided at:

a. The following explicitly identifies responsibilities for the section 8(2)(m)(i) analysis in the context of a death or serious injury in custody:
    i. The implicated Regional Office (Ops) completes the Matrix and may contact the ATIP / Information Sharing & Collaborative Arrangements Policy Unit for guidance when filling in the Matrix
    ii. The Regional Director General submits the Matrix to the Vice-President of Operations (VP Ops)
    iii. The VP Ops approves the Matrix and forwards it to the Vice-President of Corporate Affairs (VP CAB)
    iv. VP CAB approves or rejects public disclosure
    v. ATIP notifies the Office of the Privacy Commissioner, if approved.

2. Any further public comment that is case-specific should be the responsibility of the external investigative body.

While the matter is under investigation by police / coroner:

1. The CBSA will adopt a responsive approach.
    - It is recommended media be referred to the NR posted online, and indicate that 'it would be inappropriate to comment further at this time as this is still under investigation.
    - Consideration may be given to responding in a general manner to questions, but need to avoid addressing case-specific questions while the investigation is ongoing.

- Once the police / coroner's office have concluded their investigations, we may consider publicly releasing additional information as appropriate, , posting an update to our website or updating our media lines accordingly.

If a Coroner's inquest is announced:

- During the period leading up to, and during, the inquest, the public environment will be monitored and messages may be adjusted accordingly. Corrective tweeting is also recommended as appropriate, with links to fact sheets, news releases, etc.

Following the release of the Coroner's report:

- Immediately following the release of the report, responsive holding lines should indicate that we are carefully reviewing the recommendations in the report.
- As soon as reasonably possible following the issuance of the coroner's report, a NR may be issued to acknowledge the completion of the inquest and outline any steps, as applicable to the CBSA, that we have and will further take to address concerns that may have arisen during the inquest.
- Until or unless otherwise directed, the Government of Canada does not "respond" in detail, or on a point-by-point basis, to recommendations from a provincial authority.

ANNEX A

Draft News Release

Visit the Branding Templates page for text spacing.

Death [or serious injury] of a detainee at [name of immigration holding centre, provincial facility or hospital].

Date
Ottawa, ON
Canada Border Services Agency

On [date], first responders were called to the [name of immigration holding centre or provincial facility or hospital] in [location] and a [X-year old male/female] detainee was [sent to a local hospital OR pronounced dead]. The [man/woman] passed away [in hospital] on [date], OR [The man/woman remains in hospital].

The man/woman has been identified as [name] - OR

The [man's/woman's] identity will not be released at this time.

The family of the deceased [OR injured detainee] have been notified.

As in all cases involving the death in CBSA custody, the police and the coroner have been notified. The CBSA will also be reviewing the circumstances of the incident- OR - The police are investigating the incident, and as in all cases involving serious death of an individual in CBSA custody, the CBSA will be reviewing the circumstances of the incident.

The CBSA is not in a position to release further information while the investigation is ongoing.

Links

For more information about the law and policies about detention, please consult the CBSA website and Information for People Detained Under the *Immigration and Refugee Protection Act* (PDF, 448 KB).

Contacts

HQ Communications

Regional Media Relations

Protocole de communications publiques — Décès ou blessure grave d'une personne en détention

En vigueur le 1er mai 2018

Le protocole suivant relatif aux communications publiques s'applique en cas de décès d'une personne détenue par l'Agence des services frontaliers du Canada (ASFC) ou de blessure grave subie par une telle personne.

Le « décès d'une personne en détention » est un incident où une personne décède pendant qu'elle se trouve sous la responsabilité, la garde ou le contrôle de l'ASFC, par exemple si elle est en état d'arrestation ou en détention dans un point d'entrée ou qu'elle est détenue dans un centre de surveillance de l'immigration de l'ASFC ou dans un établissement provincial.

Une « blessure grave » en est une qui altère considérablement le fonctionnement d'une personne (perte de la vue, perte d'un membre ou de la fonction motrice) ou qui entraîne le décès de la personne.

Veuillez également vous reporter aux bulletins opérationnels concernant les procédures à suivre en cas de décès ou de blessure grave en détention (

La présente procédure normale d'exploitation (PNE) correspond à celles des organismes partenaires du portefeuille de la Sécurité publique (Gendarmerie royale du Canada et Service correctionnel du Canada), ainsi qu'à la politique opérationnelle de l'ASFC relative aux décès en détention. En outre, l'ASFC tâchera de coordonner son approche médiatique avec l'établissement provincial concerné[1].

Application

La présente PNE s'applique aux communications de l'ASFC en lien avec le décès d'une personne détenue par l'ASFC ou une blessure grave subie par une telle personne.

Objectifs

[1] Chaque province possède ses propres règlements et adhère aux lois provinciales en ce qui concerne la divulgation d'information. Nous travaillerons donc avec ces établissements afin de coordonner nos communications, selon une approche qui tient compte de nos responsabilités et de nos rôles respectifs quant à la divulgation d'information à la suite du décès d'une personne en détention.

- Adopter une approche claire, uniforme et transparente à l'échelle de l'Agence en matière de communications publiques liées au décès d'une personne détenue par l'ASFC ou aux blessures graves subies par une telle personne, tout en respectant les politiques et les lois fédérales telles que la *Loi sur la protection des renseignements personnels*, et assurer la conformité avec les partenaires du portefeuille de la Sécurité publique.
- Fournir une tribune commune permettant de communiquer de telles situations de façon transparente et uniforme;
- Veiller à ce que toutes les communications de l'ASFC soient conformes à la *Politique de communication de l'ASFC* et à la *Politique de communication du gouvernement du Canada*, et à ce qu'elles respectent la *Loi sur la protection des renseignements personnels*, la *Loi sur les langues officielles*, les politiques de l'ASFC et les règlements connexes.

Processus

Immédiatement après le décès d'une personne en détention ou une blessure grave subie par une telle personne :

1. Procéder à une analyse au titre du sous-alinéa 8(2)*m*)(i) de la *Loi sur la protection des renseignements personnels* dans les 72 heures suivant l'avis des autorités. Le processus est décrit en ligne :

    ○

    ○

Diffuser un communiqué dans les 72 heures suivant l'avis des autorités, et <u>après</u> que tous les efforts possibles aient été déployés pour informer les proches. L'Agence fait ainsi preuve de souci et de compassion à la suite d'un décès ou de blessure grave, tout en favorisant une culture de transparence et de responsabilisation. Les proches seront informés le plus tôt possible afin que le processus puisse se poursuivre rapidement et de façon responsable.

2. Le communiqué suivra le modèle à l'annexe A et sera publié sur le fil de presse, affiché dans la salle de rédaction du site Canada.ca et diffusé sur Twitter.
    - Le communiqué comprendra le nom de la personne détenue (s'il est question d'intérêt public), son sexe et son âge. Cette mesure permettra à l'Agence de faire preuve de toute la transparence possible tout en respectant les dispositions de la *Loi sur la protection des renseignements personnels*.
    - Le communiqué comprendra des renseignements généraux sur l'événement, soulignant par le fait même l'engagement de l'ASFC envers la transparence et la responsabilisation. Le communiqué décrira brièvement la situation sans compromettre la sécurité, le droit à la vie privée ou toute enquête en cours. Les précisions fournies comprendront la date et le lieu de l'événement, les premiers

intervenants sur les lieux, la date à laquelle la personne est décédée, et les organismes participant à l'enquête.
- Le communiqué devrait se terminer par une mention que l'ASFC ne peut diffuser aucun autre renseignement pendant la tenue de l'enquête.

3. L'Administration centrale (AC) rédigera les produits de communication en tenant compte des commentaires des Opérations ou de la région, et obtiendra les approbations nécessaires, au besoin.
   - Les Opérations ou la région doivent informer les Communications ou l'AC **aussitôt** qu'elles sont mises au fait du décès d'une personne en détention, conformément au protocole opérationnel

   - Les communiqués relatifs à un décès ou à une blessure grave en détention sont des communiqués de « catégorie 3 » et exigent l'approbation des vice-présidents, de la première vice-présidente et du président (veuillez vous reporter au protocole concernant les demandes de renseignements des médias).
4. On tâchera de coordonner le contenu et l'échéancier du communiqué avec les organismes provinciaux, mais peu importe les plans des partenaires, le communiqué sera présenté à la première vice-présidente, au président et au ministre aux fins de vérification. Les partenaires, tels que le corps policier qui mène l'enquête, seront avisés au préalable de la diffusion du communiqué.
5. Selon la nature de l'incident, un message interne pourrait également être diffusé.

Après la diffusion du communiqué de l'ASFC :

1. Les communications peuvent divulguer des renseignements supplémentaires, si approprié, dans le cadre du processus approuvé, afin de renforcer l'engagement de l'ASFC envers la transparence et la responsabilisation, sans compromettre la sécurité, la protection de la vie privée ou les procédures d'enquête.

Renseignements supplémentaires sur les analyses au titre du sous-alinéa 8(2)*m*)(i) :

a. La liste suivante décrit en détail les responsabilités associés aux analyses au titre du sous-alinéa 8(2)*m*)(i) dans le contexte d'un décès ou de blessures graves en détention :
   i. Le bureau des opérations régional concerné remplit la matrice, et pourrait demander des conseils à l'Unité des politiques sur l'échange d'information et

les ententes de collaboration de la Division de l'AIPRP pour remplir la matrice.

ii. Le directeur général régional présente la matrice au VP, Opérations.
iii. Le VP, Opérations, approuve la matrice et la transmet au VP, Services intégrés.
iv. Le VP, Services intégrés, approuve ou refuse la divulgation publique.
v. Si la divulgation est approuvée, l'AIPRP en avise le Commissariat à la protection de la vie privée.

2. Tout commentaire public et spécifique devrait relever de l'organisme d'enquête externe.

Pendant l'enquête des corps policiers / du bureau du coroner :

1. L'ASFC adoptera une approche réactive.
    - Il est recommandé de renvoyer les médias au communiqué en ligne et de préciser qu'il n'est pas indiqué de formuler d'autres commentaires pour l'instant vu que l'enquête est toujours en cours.
    - On pourrait envisager de répondre de façon générale aux questions, tout en évitant les questions spécifiques sur le dossier pendant la tenue de l'enquête.
    - Après que les corps policiers et le bureau du coroner auront terminé leur enquête, l'Agence pourrait envisager de diffuser un nouveau communiqué, de publier une mise à jour sur son site Web ou de mettre à jour les infocapsules en conséquence.

Si une enquête du coroner est annoncée :

- Pendant la période précédant la tenue de l'enquête, ainsi que l'enquête même, l'Agence surveillera l'environnement public et pourra ajuster ses messages en conséquence. Des gazouillis correctifs sont également recommandés, le cas échéant, pour fournir des liens vers des documents d'information, des communiqués, etc.

Après la diffusion du rapport d'enquête du coroner :

- Immédiatement après la diffusion du rapport, des infocapsules réactives devraient indiquer que l'Agence examine attentivement les recommandations du rapport.
- Le plus tôt possible après la diffusion du rapport d'enquête du coroner, l'Agence pourrait publier un communiqué soulignant la fin de l'enquête et décrivant les mesures relevant de l'Agence qui ont été prises et qui seront prises en réponse aux préoccupations soulevées au cours de l'enquête.
- À moins d'indication contraire, le gouvernement du Canada ne doit pas « répondre » en détail, ou point par point, aux recommandations provenant d'une autorité provinciale.

ANNEXE A

Ébauche de communiqué

Consultez le lien Modèles – Image de marque pour voir l'emplacement des paragraphes.

Décès [ou blessures graves] d'une personne en détention au [nom du centre de surveillance ou de l'hôpital].

Date
Ottawa (Ontario)
Agence des services frontaliers du Canada

Le [date], les premiers intervenants ont été appelés au [nom du centre de surveillance de l'immigration ou de l'hôpital] à [endroit] un/une détenu(e) âgé(e) de [âge] [a été transporté(e) à l'hôpital OU a été prononcé(e) mort(e)]. L'homme/La femme est décédé(e) [à l'hôpital] le [date], OU [L'homme/la femme demeure hospitalisé(e)].

L'homme/la femme a été identifiée comme étant [nom] – OU – Son identité ne sera pas divulguée pour l'instant.

Les proches du défunt/de la défunte [ou de la personne blessée] ont été informés.

Comme dans tous les cas de décès d'une personne détenue par l'ASFC, les services de police et le bureau du coroner ont été avisés. L'ASFC examinera également les circonstances de l'incident. - OU – Les services de police font enquête et, comme dans tous les cas de décès d'une personne détenue par l'ASFC, l'Agence examinera les circonstances de l'incident.

L'ASFC ne peut communiquer de renseignements supplémentaires pendant que l'enquête est en cours.

Links

Pour en savoir plus sur la loi et les politiques qui encadrent la détention, veuillez consulter le document d'information sur la détention et le document Renseignements à l'intention des personnes détenues en vertu de la *Loi sur l'immigration et la protection des réfugiés* (PDF, 448 Ko).

Personnes-ressources

Communications de l'AC

Équipe régionale des relations avec les médias